

BIRTH NO. 65 12501 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
SEAN STEVENS		December 4, 1965 7:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
Johns Hopkins Hospital		Maryland	
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
		Baltimore	
		D. STREET ADDRESS (If rural, give location)	
		2318 E. Baltimore Street	

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Male	White		October 23, 1965	1	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Ronald Stevens		Irene Crewsman (Kreuzmann)		U.S.A.	

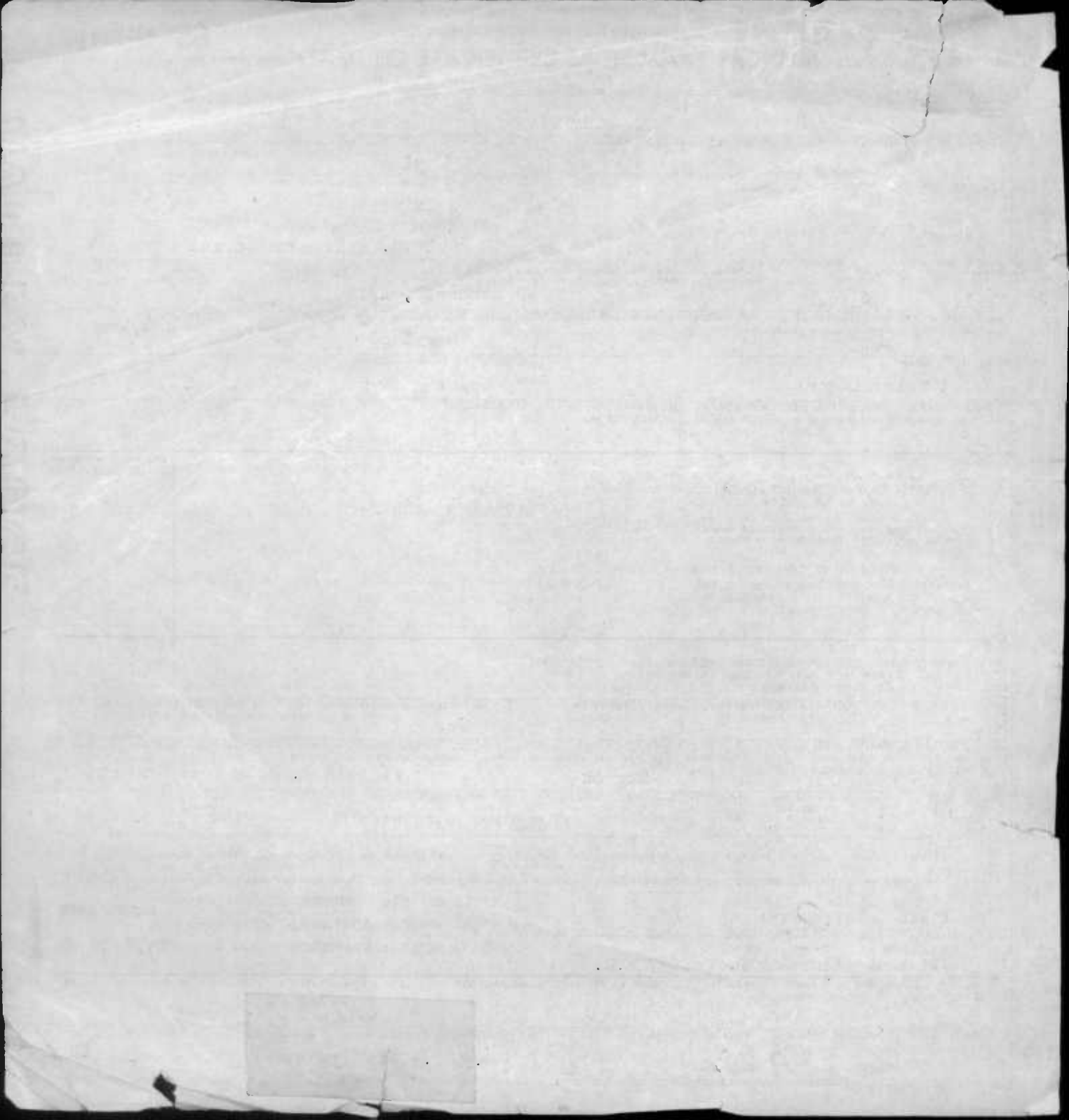
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		2318 E. Baltimore St

18. CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)	
Craniocerebral Injury.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
	Street	Front of 2318 E. Baltimore Street	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)	WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	Thrown from runaway stroller.	
12 3 '65 P			

22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
ACTUAL SIGNATURE	M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)	ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	12/5/65
Charles S. Petty, M.D.		

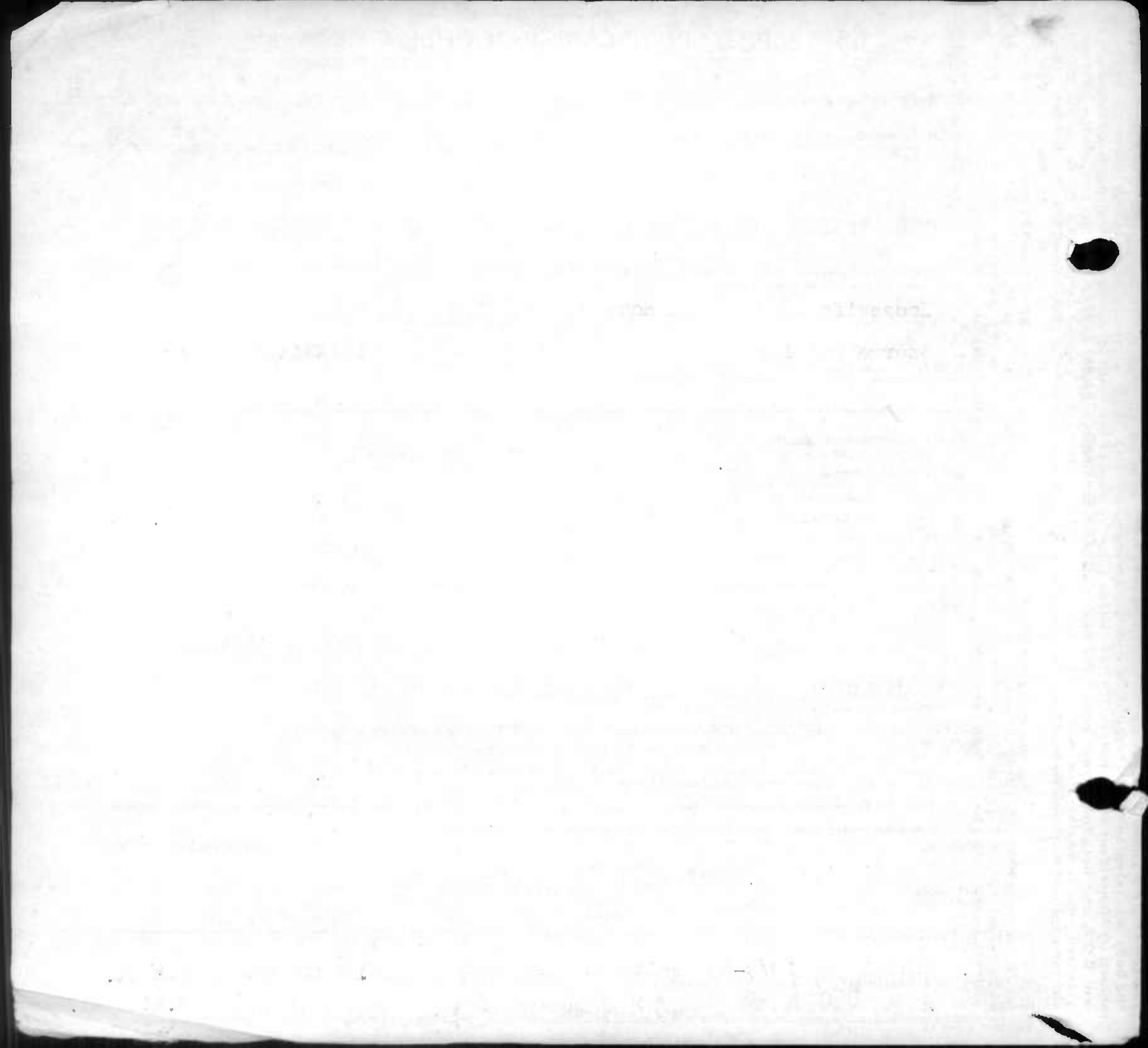
23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME OF CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12/8/65	Baltimore	Baltimore
24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 8 1965	Robert E. [unclear]	Philip H. [unclear]	2024 Orleans St



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

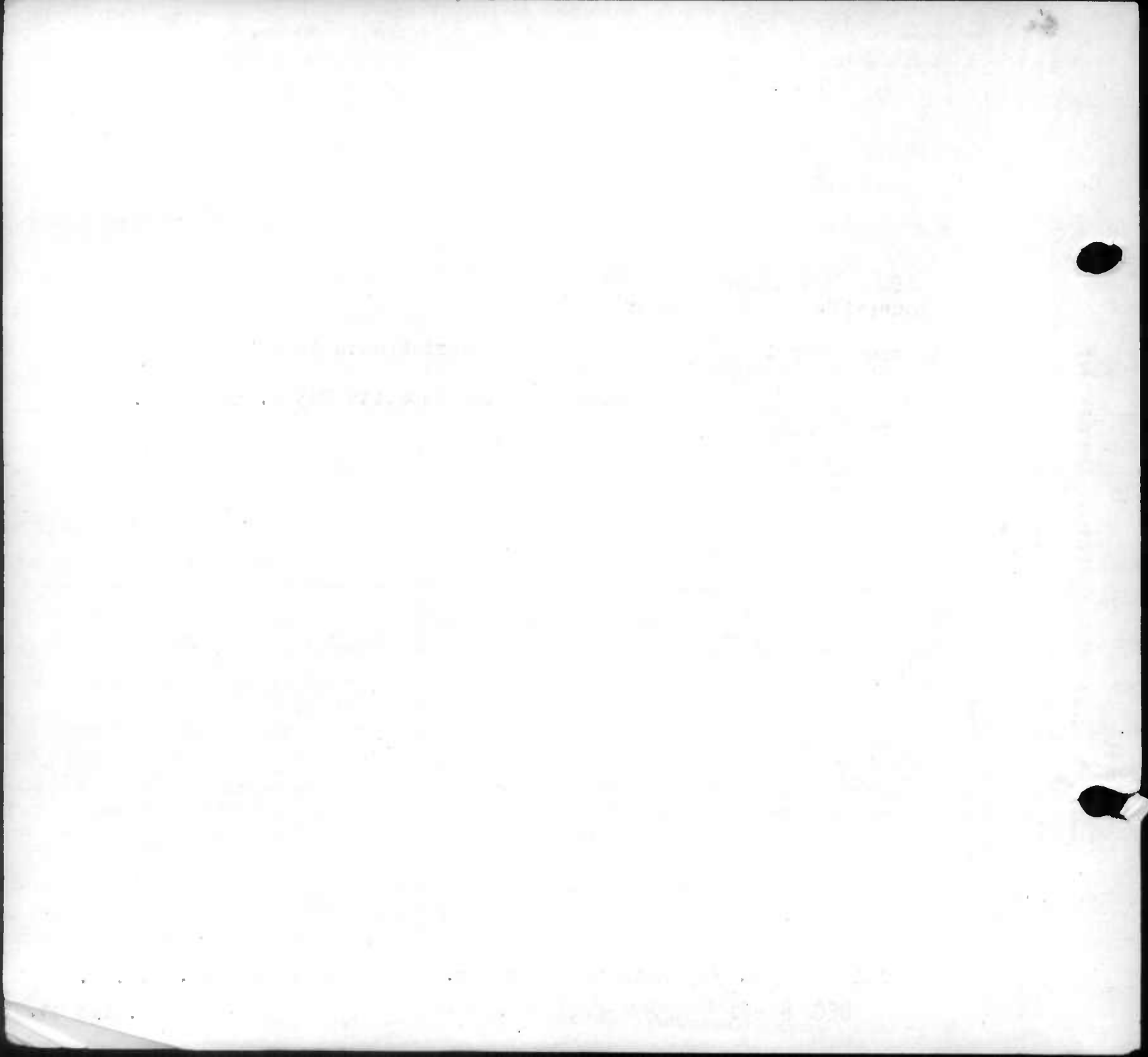
BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 65 12502	
BIRTH NO. 65 12502		CERTIFICATE OF DEATH								Registered No. 65 12502	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BOYD, STELLA S.						2. DATE AND HOUR OF DEATH 12.6.1965 1 6³⁰ A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BON SECOURS HOSP						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 302 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 304 S. HIGH ST.					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 6-13-88	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? USA.				
13. FATHER'S NAME George Pannier				14. MOTHER'S MAIDEN NAME SARAH XXXXXXXX Harper							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT ADMISSION SHEET.		ADDRESS			
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Central accident DUE TO (B) generalized arteriosclerosis DUE TO (C) 3 days INTERVAL BETWEEN ONSET AND DEATH 12.3.1965 12.6.1965 3 days											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from 12.3.1965 to 12.6.1965 , that (I) (we) last saw the deceased alive on 12.5.1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Dr. Boelmer					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 12.6.19			
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D.						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9-65		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery			24D. LOCATION (City, town, or county) (State) E. North Ave & Rose St.				
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1965		25B. NAME OF REGISTRAR Robert E. Johnson			25C. FUNERAL DIRECTOR Granny Stella Hoe			ADDRESS 322 S. High St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

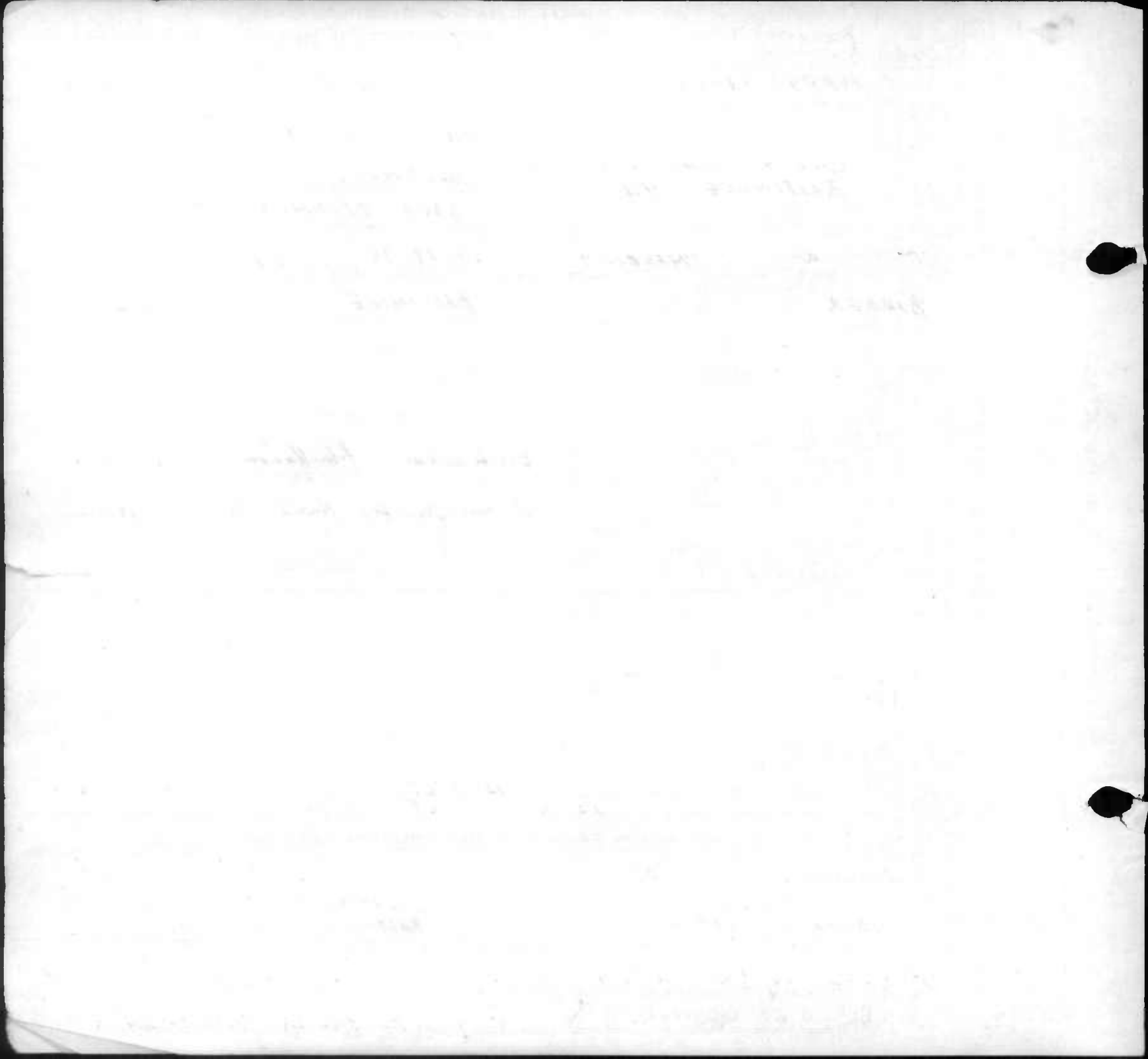
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12503	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 65 12503</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) MATILDA CIPOLLONI</p> </div> <div> <p>2. DATE AND HOUR OF DEATH Dec. 6 1965 9:30 AM.</p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSPITAL</p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 3-02</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE</p> <p>D. STREET ADDRESS (If rural, give location) 239 ALBEMARLE</p>		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 4/30/1894	9. AGE (In years last birthday) 71	<p>If Under 1 Yr. Months Days</p> <p>If Under 24 Hrs. Hours Min.</p>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) ITALY	
13. FATHER'S NAME Vincenzo Cozzi			14. MOTHER'S MAIDEN NAME Mariassunta Ippolito		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS Ida Esposito 203 S. Exeter St.	
<p>18. 420.11 CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<p>22. I certify that (I) (this hospital) attended the deceased from DEC. 1 19 65 to DEC. 6 19 65, that (I) (we) last saw the deceased alive on DEC. 6 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
23A. SIGNATURE Wilfredo H. Mediano M.D.				23B. DATE SIGNED DEC. 6, 1965	
23C. PHYSICIAN'S NAME (Type) WILFREDO H. MEDIANO			23D. ADDRESS FRANKLIN SQUARE HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 9/65		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem.	
24D. LOCATION (City, town, or county) (State) 4430 Belair Rd. Balt. Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 8 1965			
25B. NAME OF REGISTRAR Frank Della Noce		25C. FUNERAL DIRECTOR ADDRESS 322 S. High st.			



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. <u>65 12504</u>	
BIRTH NO. <u>65 12504</u>		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <u>BERRY, SAMUEL</u>			2. DATE AND HOUR OF DEATH <u>12-5-65</u> <u>9:20 P</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>CHURCH HOME + HOSPITAL</u> <u>BALTIMORE, MD.</u>			A. STATE <u>MD.</u> B. COUNTY <u>U.S.A.</u>		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			D. STREET ADDRESS (If rural, give location) <u>3303 CLIAMONT AVE.</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>7-27-98</u>	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARBER</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
18. <u>420.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Antecedent Causes</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>Ventricular Fibrillation</u> DUE TO (B) <u>Atherosclerotic Heart Disease</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>none</u>
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>none</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-3-65</u> 19 to <u>12-5</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12-5</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>S. MARIANO, M.D.</u>				23B. DATE SIGNED <u>12-5-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>IDILIA C. MARIANO</u>		23D. ADDRESS <u>CHURCH HOME + HOSPITAL</u> <u>BALTIMORE, MD. 21231</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>12/9/65</u>	24C. NAME of CEMETERY or CREMATORY <u>GARDENS OF FAITH</u>		24D. LOCATION (City, town, or county) (State) <u>TRUMPS MILL RD MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>DIPPER RD INC THIBLAIR RD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12505	
BIRTH NO. 65 12505		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CZERKOVICH, ANDREW (NMI)			2. DATE AND HOUR OF DEATH December 7, 1965 9:45 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Blvd., Baltimore, Maryland 21218			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 208 N. Rose Street		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 11/30/90	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAR REPAIRMAN		10B. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (State or foreign country) RUSSIA	
13. FATHER'S NAME GUNTINTINE CZERKOVICH			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 7/25/18 to 12/26/18			16. SOCIAL SECURITY NO. 705 03 5137		
17. INFORMANT VA Hospital, Baltimore, Md. 21218			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA, ORGANISM UNKNOWN			INTERVAL BETWEEN ONSET AND DEATH 2 or 3 days		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			PULMONARY EMPHYSEMA 5 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CEREBRAL THROMBOSIS			OLD		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (✓) (this hospital) attended the deceased from December 6, 1965 to December 7, 1965 , that (✓) (we) lost saw the deceased alive on December 7, 1965 and that in (✓) (our) opinion death occurred on the date and hour and from the causes stated above. (✓) (We) (did) (did not) view the body after death.					
23A. SIGNATURE DAVID N. MARINE				23B. DATE SIGNED 12/7/65	
23C. PHYSICIAN'S NAME (Type) DAVID N. MARINE		23D. ADDRESS M.D. 3900 Loch Raven Blvd., Baltimore, Md. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec 10 1965		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem	
24D. LOCATION Frederick Road		24E. STATE Md		24F. CITY, TOWN, OR COUNTY Baltimore	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1965		25B. NAME OF REGISTRAR Robert E. Stapp		25C. FUNERAL DIRECTOR The Dippel Bros Inc 1800 E Lombard St	



G. 246

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

65 12506

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12506

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN A GEISLER Sr

2. DATE AND HOUR PRONOUNCED DEAD

12-5-65

10:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNIVERSITY HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3002 Glendale Avenue 21234

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Dec 2 1904

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Supt

10B. KIND OF BUSINESS OR INDUSTRY

Sgram Co

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Louis Geisler

14. MOTHER'S MAIDEN NAME

Jennie Dorbert

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-05-1176

17. INFORMANT

Elizabeth K. Geisler 3002 Glendale Ave

ADDRESS

18.

4221 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TOII
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

CHAS. S. PETTY, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-6-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Dec 9 1965

23C. NAME of CEMETERY or CREMATORY

Gardens of Faith Cem.

23D. LOCATION

(City, town, or county)

Trumps Mill Road

Md

24A. DATE REC'D BY HEALTH DEPT.

DEC 8 1965

24B. NAME OF REGISTRAR

Robert E. Fajana

24C. FUNERAL DIRECTOR

Dippel Bros Inc 7110 Belair Road

ADDRESS

WALL BENE
STINGE

Dec 2 1901

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Belgium

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Louis Borden

Louis Borden

MISSISSIPPI, December 2, 1901

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Dec 2 1901
L. Borden of X-ray Co.

Mississippi

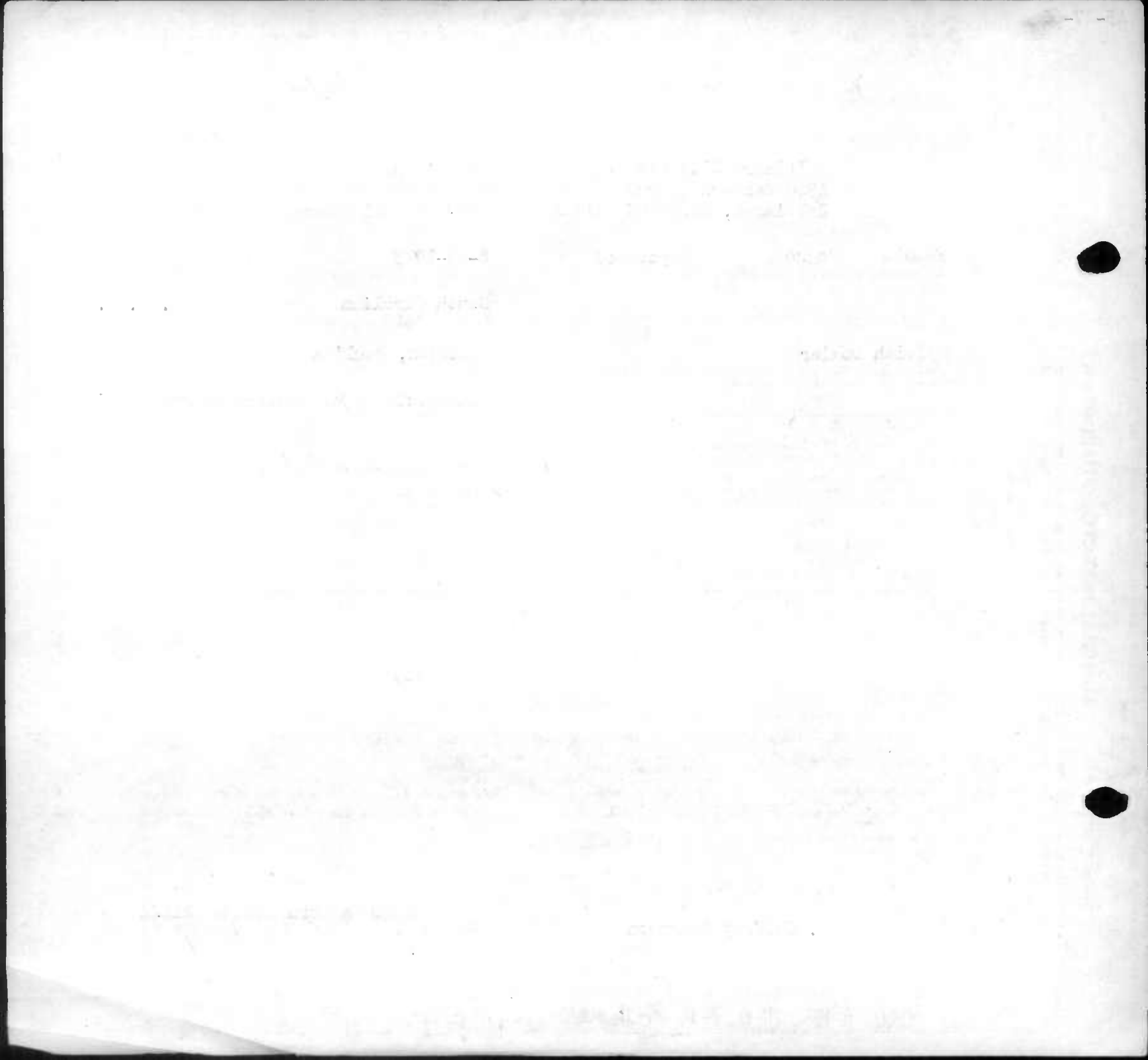
45-27-65

W-305

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

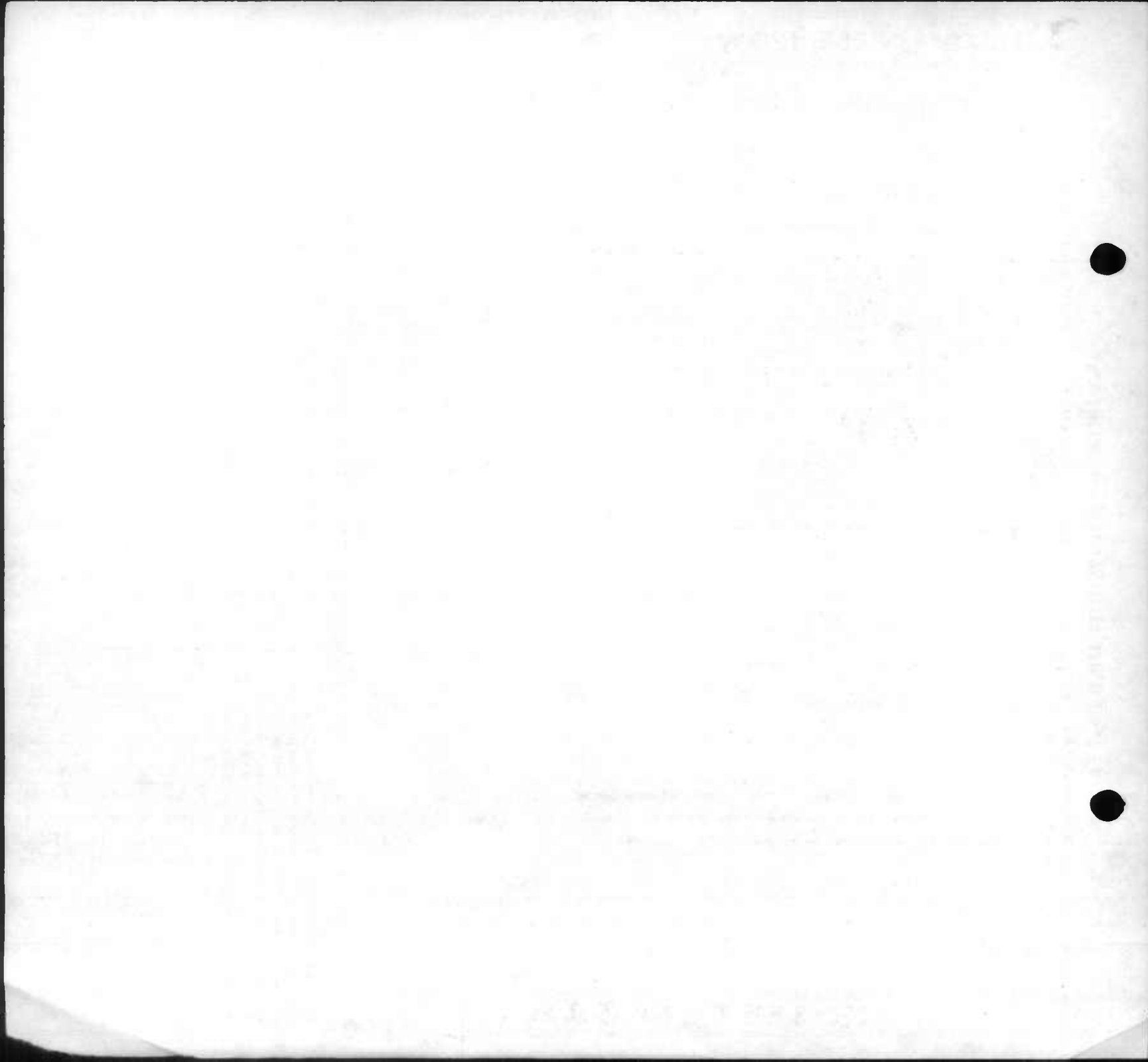
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12507	
BIRTH NO. 65 12507		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Watson, Harriet</i>		2. DATE AND HOUR OF DEATH <i>12/6/65</i> <i>5⁰⁵ P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>25-32</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>307 Seagull Avenue 21225</i>			
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Separated</i>	8. DATE OF BIRTH <i>8-23-1923</i>	9. AGE (In years last birthday) <i>42</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>	
13. FATHER'S NAME <i>Isiah Dozier</i>		14. MOTHER'S MAIDEN NAME <i>Gibson, Pauline</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>RECORDS: BCH 4940 Eastern Avenue 21224</i>	
18. <i>45-21X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Anterior Communicating Aneurysm</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11-23</i> 19 <i>65</i> to <i>12-6</i> 19 <i>65</i> , that (I) (<i>we</i>) last saw the deceased alive on <i>12-6</i> 19 <i>65</i> and that in (my) (<i>our</i>) opinion death occurred on the date and hour and from the causes stated above. (I) (<i>we</i>) (<i>did</i>) (<i>did not</i>) view the body after death.					
23A. SIGNATURE <i>Jeffrey P. Aaronson</i>				23B. DATE SIGNED <i>12-6-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. Jeffrey Aaronson</i>		23D. ADDRESS <i>4940 Eastern Avenue 21224 Baltimore City Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/10/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt Calvary</i>	
24D. LOCATION <i>Brooklyn, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 8 1965</i>			
25B. NAME OF REGISTRAR <i>Charles E. Johnson</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Charles E. Johnson 661 W. Barre St</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12508	
BIRTH NO. 65 12508				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) SAMUEL NELSON RUBY				12-5-65 1 10 30 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospital				A. STATE MARYLAND	
				B. COUNTY 19-04	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
				D. STREET ADDRESS (If rural, give location) 511 South Vincent St	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4-25-86	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 2.			10B. KIND OF BUSINESS OR INDUSTRY 2.		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME 2.			14. MOTHER'S MAIDEN NAME 2.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 2.			16. SOCIAL SECURITY NO. 218-1438371		17. INFORMANT ADDRESS Pt's chart at hospital
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I G.I. tract Malignancy				CAUSE OF DEATH 7.	
				INTERVAL BETWEEN ONSET AND DEATH 7.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II ASCVD				1950	
19A. DATE OF OPERATION 0 0 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 0		20A. AUTOPSY? (Yes or No) 0	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 0		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 0		21C. WHERE DID INJURY OCCUR? 0	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 0		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? 0	
22. I certify that (H) (this hospital) attended the deceased from 11-17 19 65 to 12-5 19 65 , that (H) (we) lost saw the deceased alive on 12-5 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Henry A. Jarvitz				23B. DATE SIGNED 12-5-65	
23C. PHYSICIAN NAME (Type) Henry A. Jarvitz				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-8-65		24C. NAME OF CEMETERY or CREMATORY St Mary's Hospital	
24D. LOCATION (City, town, or county) (State) Baltimore Md					
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1965		25B. NAME OF REGISTRAR Robert E. Jarvitz		25C. FUNERAL DIRECTOR ADDRESS Frank J. Jarvitz 814 W 36th St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 65 12509	
CERTIFICATE OF DEATH											
BIRTH NO. 65 12509		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Kenneth Lafayette Anderson				2. DATE AND HOUR OF DEATH Dec. 5, 1965 10:20 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st St.						A. STATE Ohio					
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) Rt. 3 Cadiz					
						D. STREET ADDRESS (If rural, give location)					
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 9/30/24		9. AGE (In years last birthday) 41		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur Anderson						14. MOTHER'S MAIDEN NAME Mary Douglas					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes USA 1943-1945				16. SOCIAL SECURITY NO. 273-20-8652		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.					
18. 201X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)						CAUSE OF DEATH					
						(A) DUE TO Pulmonary edema					
						(B) DUE TO Hodgkin's disease involving lungs, liver, pancreas, spleen, thoracic and abdominal lymph nodes					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						Bilateral pleural effusions & cardiac hypertrophy					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Oct. 14 19 65 to Dec. 5 19 65, that (I) (we) last saw the deceased alive on Dec. 5 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Thomas J. Lau M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>										23B. DATE SIGNED 12/6/65	
23C. PHYSICIAN'S NAME (Type) Thomas J. Lau, Surgeon (R) M.D.						23D. ADDRESS US PHS Hospital, Balto, M d.					
24A. BURIAL OR REMOVAL (Specify)		24B. DATE 12-9-65		24C. NAME OF CEMETERY or CREMATORY ROCK HILL				24D. LOCATION (City, town, or county) (State) FLUSHING, OHIO			
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1965				25B. NAME OF REGISTRAR Robert E. Taylor				25C. FUNERAL DIRECTOR ADDRESS MITCHELL-WIEDEFFELD HOME 6520 YORK RD. BALTO.			

12-1-52 Black Hills
F. J. Smith, Chgo
Mittelman, 1100 E. 1st St
Chicago, Ill.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 12510</u>	
BIRTH NO. <u>65 12510</u>		CERTIFICATE OF DEATH			
M.E. CASE NO. <u>65 12510</u>					
1. NAME OF DECEASED (Type or Print) <u>EFFIE W. KANTNER</u>		2. DATE AND HOUR OF DEATH <u>DECEMBER 5, 1965</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Haven Nursing Home</u> <u>3939 Penhurst Road</u>		A. STATE <u>West Virginia</u> B. COUNTY <u>V-45</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Martinsburg</u>			
		D. STREET ADDRESS (If rural, give location) <u>512 W. King St.</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 9, 1869</u>	9. AGE (In years last birthday) <u>96</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
13. FATHER'S NAME <u>William H. Kantner</u>		14. MOTHER'S MAIDEN NAME <u>Margaret M. Wilen</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT ADDRESS <u>Dr. Leahmer M. Kantner 2016 Park Ave.</u>	
18. <u>450.0</u>		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>Supernatural</u>		(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <u>Generalized arteriosclerosis</u>			
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<u>0</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>64</u> to <u>12-5</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12-7</u> 19 <u>65</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. Thomas G. Abbott</u> M.D.				23B. DATE SIGNED <u>12-5-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Thomas G. Abbott</u> M.D.				23D. ADDRESS <u>4509 Liberty Heights Ave. Balto., Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<u>Burial-Transit</u>		<u>12-8-65</u>		<u>Green Hill</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<u>DEC 8 1965</u>		<u>John O. Mitchell & Sons-Wiedefeld, Inc</u>		<u>6500 York Road Baltimore, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. 65 12511 Registered No. 65 12511

M.E. CASE NO. 65 12511

1. NAME OF DECEASED (Type or Print) LOUIS SLOMBA 2. DATE AND HOUR OF DEATH 12/6/65 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE md. B. COUNTY Bolte

C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location) 7916 BRIDGE AVENUE

5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M 8. DATE OF BIRTH 7/22/08 9. AGE (In years last birthday) 57 If Under 1 Yr. Months: Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HAND SLITTER Steel-Tin Products Co. 10B. KIND OF BUSINESS OR INDUSTRY Steel-Tin Products Co. 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME JOHN SLOMBA 14. MOTHER'S MAIDEN NAME CLARA ZABAWA

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 213-05-9048 17. INFORMANT ADDRESS Frances T. Slomba 7916 Bridge Ave

18. 7-20-14-201X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CONGESTIVE HEART FAILURE (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Acute RENAL FAILURE & HEART FAILURE
BRONCHOPNEUMONITIS, SUSPECTED
CORONARY HEART DISEASE
HODGKIN'S DISEASE
BRONCHO PNEUMONIA

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Yes 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ☐ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) ☐ 21E. INJURY OCCURRED While At ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 12/3 1965 to 12/6 1965, that (1) we saw the deceased alive on 12/6 1965 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death.

23A. SIGNATURE Bruce A. Brian M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type) BRUCE A. BRIAN M.D. 23D. ADDRESS University Hospital

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 12-10-65 24C. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery 24D. LOCATION (City, town or county) (State) Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT. DEC 8 1965 25B. NAME OF REGISTRAR Philip F. Guech 25C. FUNERAL DIRECTOR ADDRESS 1211 Chosaco Ave

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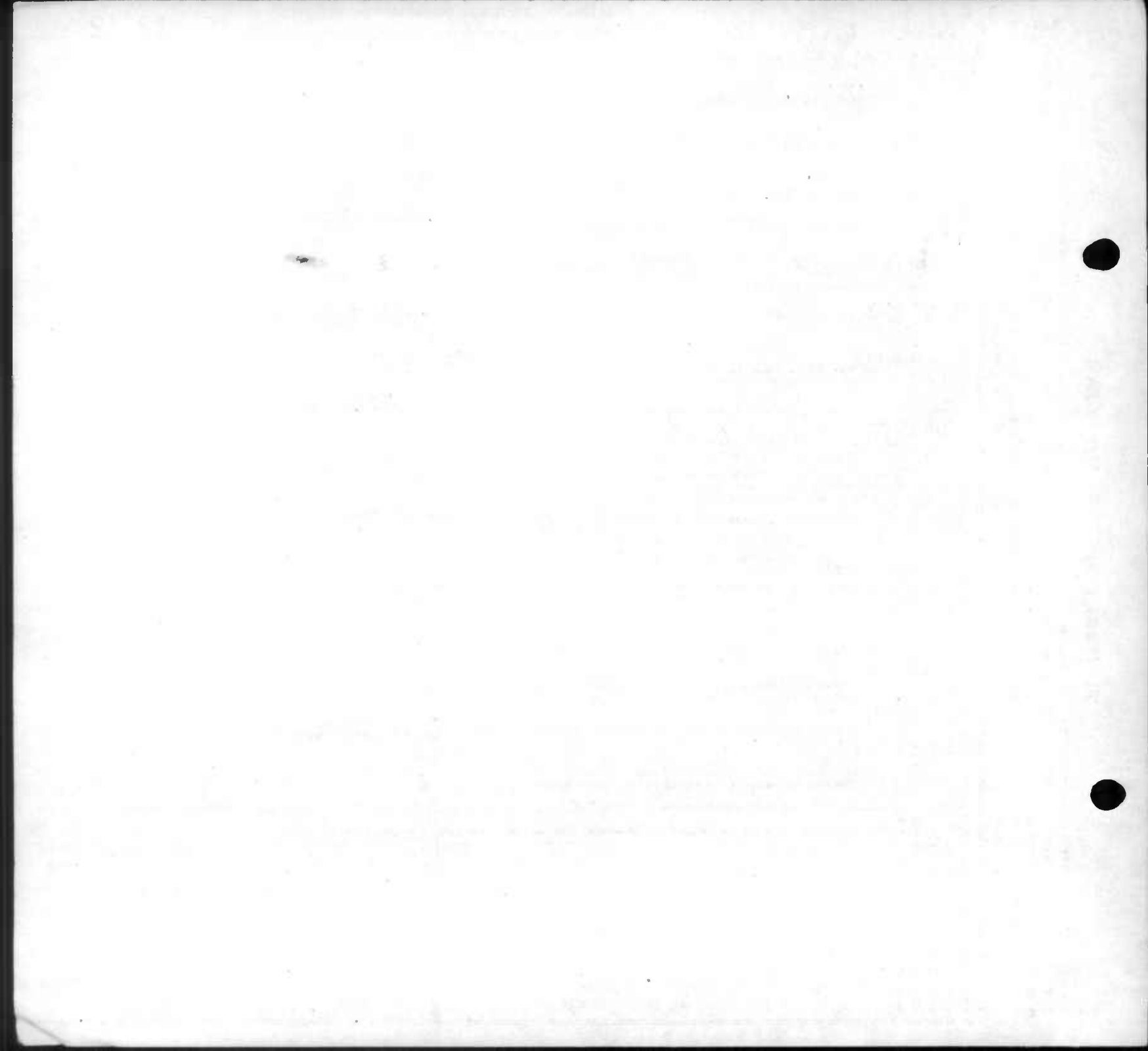
1951/2

1951/2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

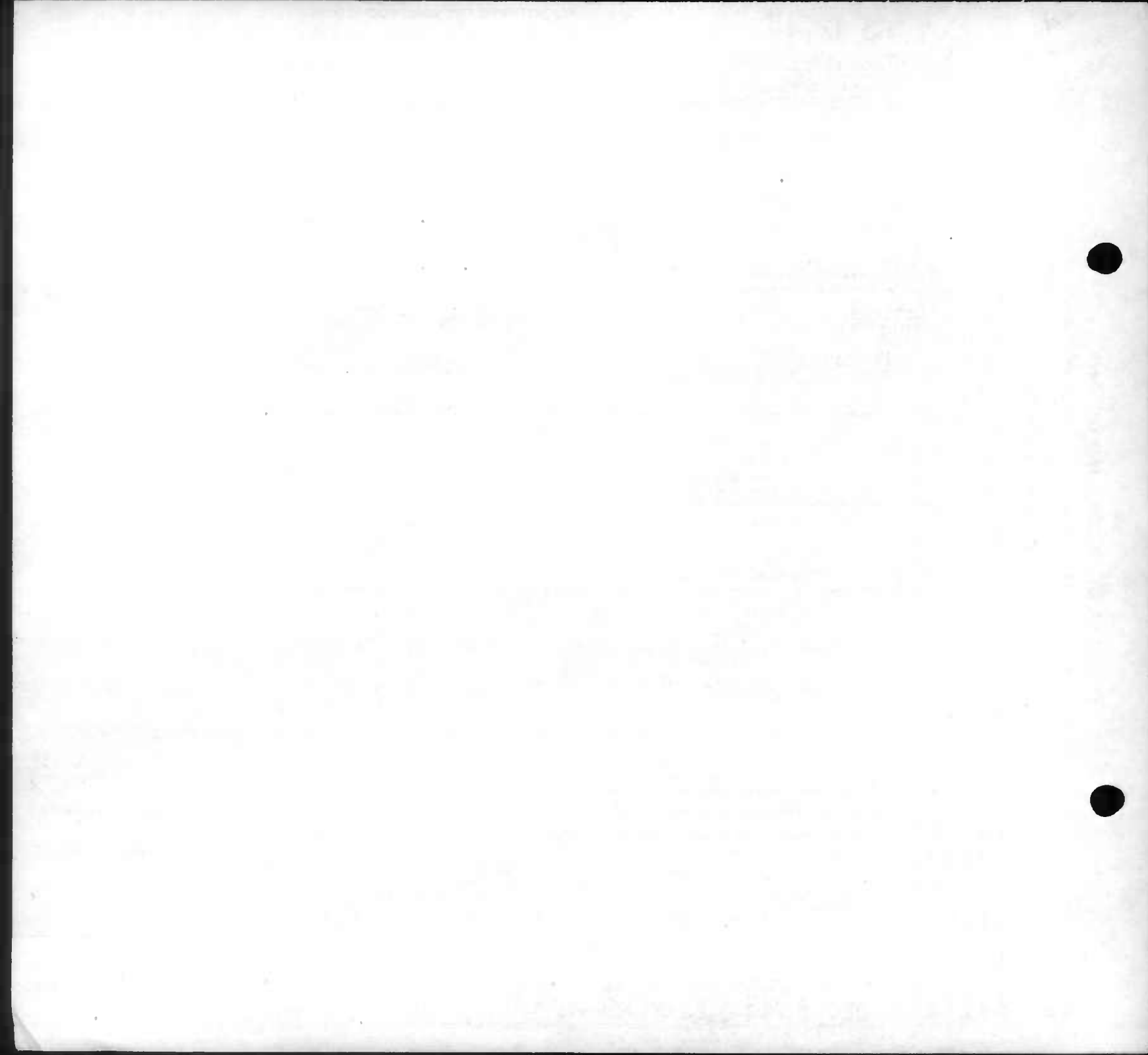
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12512	
BIRTH NO. 65 12512		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Willie A. Hart		2. DATE AND HOUR OF DEATH December 3, 1965 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1204		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 346 E. 22nd Street Baltimore, Maryland 21218		D. STREET ADDRESS (If rural, give location) 346 E. 22nd Street			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Oct 16, 1903	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Daisy Garrison		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mary Shave 2818 Kennedy Avenue	
18. 443X-174X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cerebrovascular Accident DUE TO (B) Hypertensive Cardiovascular Disease DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Uterine Carcinoma			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JANUARY 1963 to MARCH 1965 , that (I) (we) last saw the deceased alive on MARCH 15 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jesse T. Holmes				23B. DATE SIGNED 12/6/65	
23C. PHYSICIAN'S NAME (Type) Jesse T. Holmes		23D. ADDRESS 508 E NORTH AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-7-65		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1965		25B. NAME OF REGISTRAR Robert E. Stokely		25C. FUNERAL DIRECTOR Arlington S. Phillips	
				ADDRESS 1727 Monroe St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12513		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 12513	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Oliver Strawn			
2. DATE AND HOUR OF DEATH December 4, 1965		M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 2330 N. Monroe Street Baltimore, Maryland 21217		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2330 N. Monroe Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Oct. 18, 1886	9. AGE (In years last birthday) 79	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Louis Strawn			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Walter Strawn 2330 N. Monroe Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 6 mos	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION 199.2 I		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1965 to 12 - 1965 , that (I) (we) last saw the deceased alive on 12 - 1 - 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Percival C. Smith				23B. DATE SIGNED 12-6-65	
23C. PHYSICIAN'S NAME (Type) Percival C. Smith				23D. ADDRESS 1709 Gwynn Falls Pkwy	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-8-65		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 8 1965			
25B. NAME OF REGISTRAR R. E. Stahly		25C. FUNERAL DIRECTOR Arlington S. Phillips 1727 Monroe St.			



Released by m.e. 12/4/65 5:10 AM 521

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 12514					CERTIFICATE OF DEATH					Registered No. 00 -22-19				
M.E. CASE NO.										65 12514				
1. NAME OF DECEASED (Type or Print) <u>Langford, Bessie Johnson</u>					2. DATE AND HOUR OF DEATH <u>12/4/65</u> <u>14:55</u> <u>A</u> M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>University Hospital</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>A.A.C.</u>									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>-21225</u>									
					D. STREET ADDRESS (If rural, give location) <u>106 Berlin Ave.</u> <u>52-00</u>									
5. SEX <u>♀</u>		6. RACE <u>NEGRO</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>		8. DATE OF BIRTH <u>4/23/19</u>		9. AGE (In years lost birthday) <u>46</u>		If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>				
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					13. FATHER'S NAME <u>Jack - Jones</u>					14. MOTHER'S MAIDEN NAME <u>Rose Dixon</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>					16. SOCIAL SECURITY NO. <u>216-74-4842</u>					17. INFORMANT <u>Quens Langford</u> ADDRESS <u>Same</u>				
18. <u>592X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>NONE</u>					CAUSE OF DEATH (A) <u>glomerulonephritis - chronic</u> (B) <u>unknown</u> (C) <u>unknown</u>					INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION <u>None</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>					20A. AUTOPSY? (Yes or No)				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?					22. I certify that (I) (this hospital) attended the deceased from <u>12/4/65</u> 19 to <u>12/4/65</u> 19, that (I) (we) lost saw the deceased alive on <u>12/4/65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Fred R. Eitner</u> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <u>12/4/65</u>				
23C. PHYSICIAN'S NAME (Type) <u>Fred R. Eitner</u>					23D. ADDRESS <u>University Hospital</u> M.D.									
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>12-8-65</u>					24C. NAME OF CEMETERY OR CREMATORY <u>Carmichael, Bk. Laurel</u>				
24D. LOCATION (City, town, or county) (State) <u>Md.</u>					25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1965</u>					25B. NAME OF REGISTRAR <u>Robert E. Phillips</u>				
25C. FUNERAL DIRECTOR <u>Phillips</u>					ADDRESS <u>1727 N. Monmouth</u>									



1
E. 610

BALTIMORE CITY HEALTH DEPARTMENT

65 12515

BIRTH NO. 65 12515 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CORNELIA A. ERBY

2. DATE AND HOUR PRONOUNCED DEAD

12/7/65 7:30 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1812 E. Federal St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1812 E. Federal St.

5. SEX

6. RACE

female colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

7-9-1920

9. AGE (In years
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

labor

10B. KIND OF BUSINESS OR INDUSTRY

American Sugar Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

James Edward Norman

14. MOTHER'S MAIDEN NAME

Helen Marine

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

213-14-5438

17. INFORMANT

ADDRESS

Ornat Erby, Jr. 1812 E. Federal St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Gunshot wound of head
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1812 E. Federal St.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)
12 7 65 5:15 a.m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐

NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

shot self in head

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/7/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-11-65

23C. NAME of CEMETERY or CREMATORY

Carver Memorial Park

23D. LOCATION

(City, town, or county)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 8 1965

24B. NAME OF REGISTRAR

Robert E. Farber, Jr.

24C. FUNERAL DIRECTOR

Marshall W. Jones, Jr.

ADDRESS

1735 Harford Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-6501

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 12516</u>	
BIRTH NO. <u>65 12516</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Lucille C. Bryan</u>				2. DATE AND HOUR OF DEATH <u>Dec. 7. 1965</u> <u>11:20 A.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 2327 N. Charles Street</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>9-06</u>	
5. SEX <u>female</u> 6. RACE <u>white</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>widowed</u>				8. DATE OF BIRTH <u>10-16-1894</u> 9. AGE (In years last birthday) <u>71</u>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Harry Griffin</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>216289393</u>	
17. INFORMANT <u>Mrs Donald Salisbury</u>				ADDRESS <u>5000 Sipple Ave.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>months?</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Hematoma of rt. breast + rt. arm. 1 week</u>					
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>none</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>none</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Nov. 7, 1965</u> to <u>Dec. 7, 1965</u> , that (I) (we) last saw the deceased alive on <u>Dec. 7, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Frank N. Ogden</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>Dec 8, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>FRANK N. OGDEN</u>				23D. ADDRESS <u>2701 N. Calver St</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>12-11-65</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Olivet Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc</u> ADDRESS <u>Baltimore, Md.</u>	



1
H-520

65 12517

BALTIMORE CITY HEALTH DEPARTMENT

65 12517

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) HARRY HOENIG 2. DATE AND HOUR PRONOUNCED DEAD December 7, 1965 8:05 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

3139 Northway Drive

Baltimore

D. STREET ADDRESS (If rural, give location)

3139 Northway Drive

5. SEX male 6. RACE white 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married 8. DATE OF BIRTH July 6, 1905 9. AGE (In years last birthday) 60 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Phillip J. Hoenig 14. MOTHER'S MAIDEN NAME Katherine Hoeck 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II 16. SOCIAL SECURITY NO. 220-18-6218 17. INFORMANT ADDRESS Bertha J. Hoenig 3139 Northway Dr.

18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(A) Hypertensive cardiovascular disease DUE TO (B) DUE TO (C) DUE TO

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) no 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

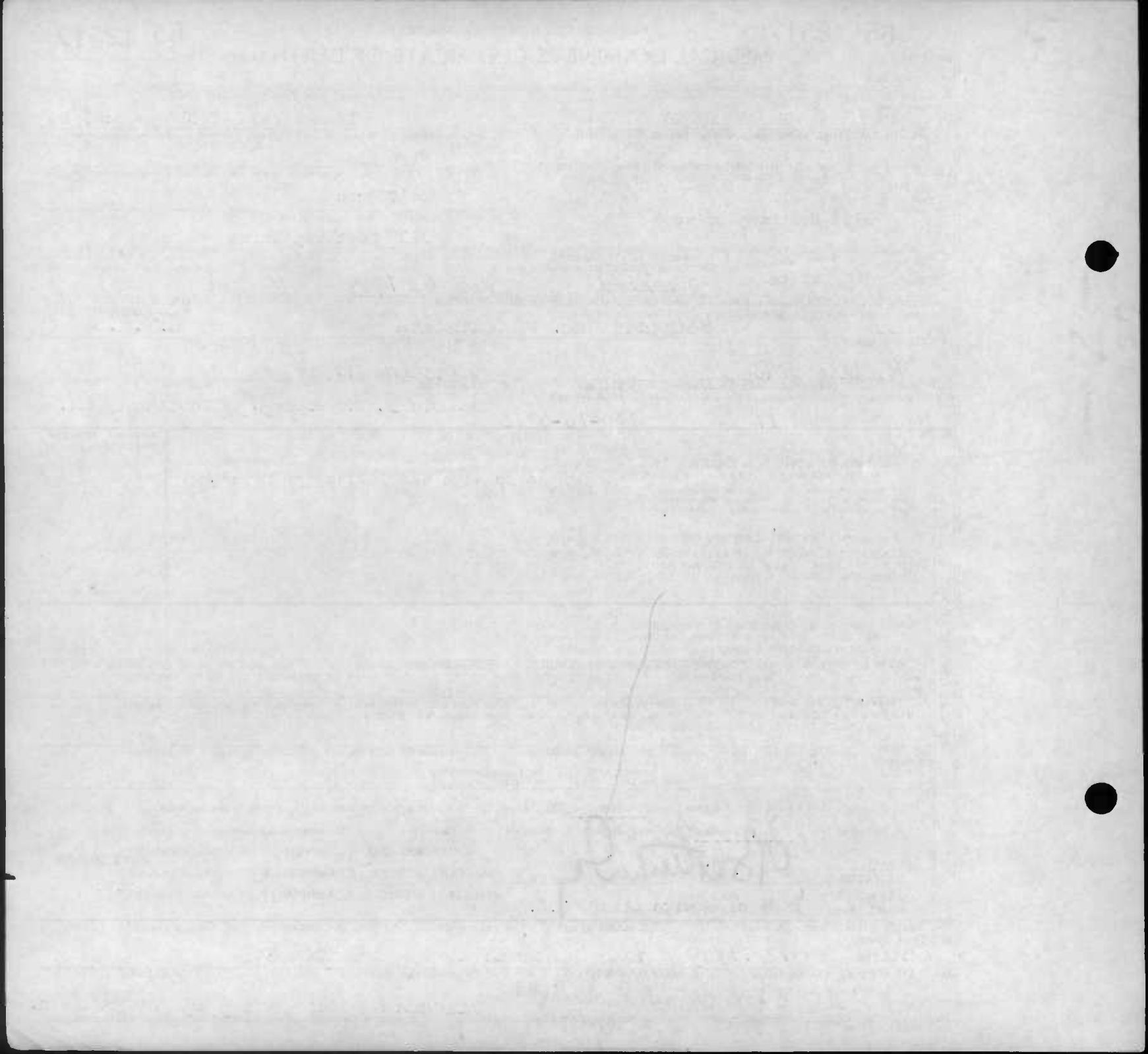
22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 12/11/65 23C. NAME of CEMETERY or CREMATORY Holy Redeemer 23D. LOCATION (City, town, or county) (State) Baltimore Md

24A. DATE REC'D BY HEALTH DEPT. DEC 8 1965 24B. NAME OF REGISTRAR Robert E. ... 24C. FUNERAL DIRECTOR Leonard J. Ruck Inc 5305 Harford Rd.

VS 151-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

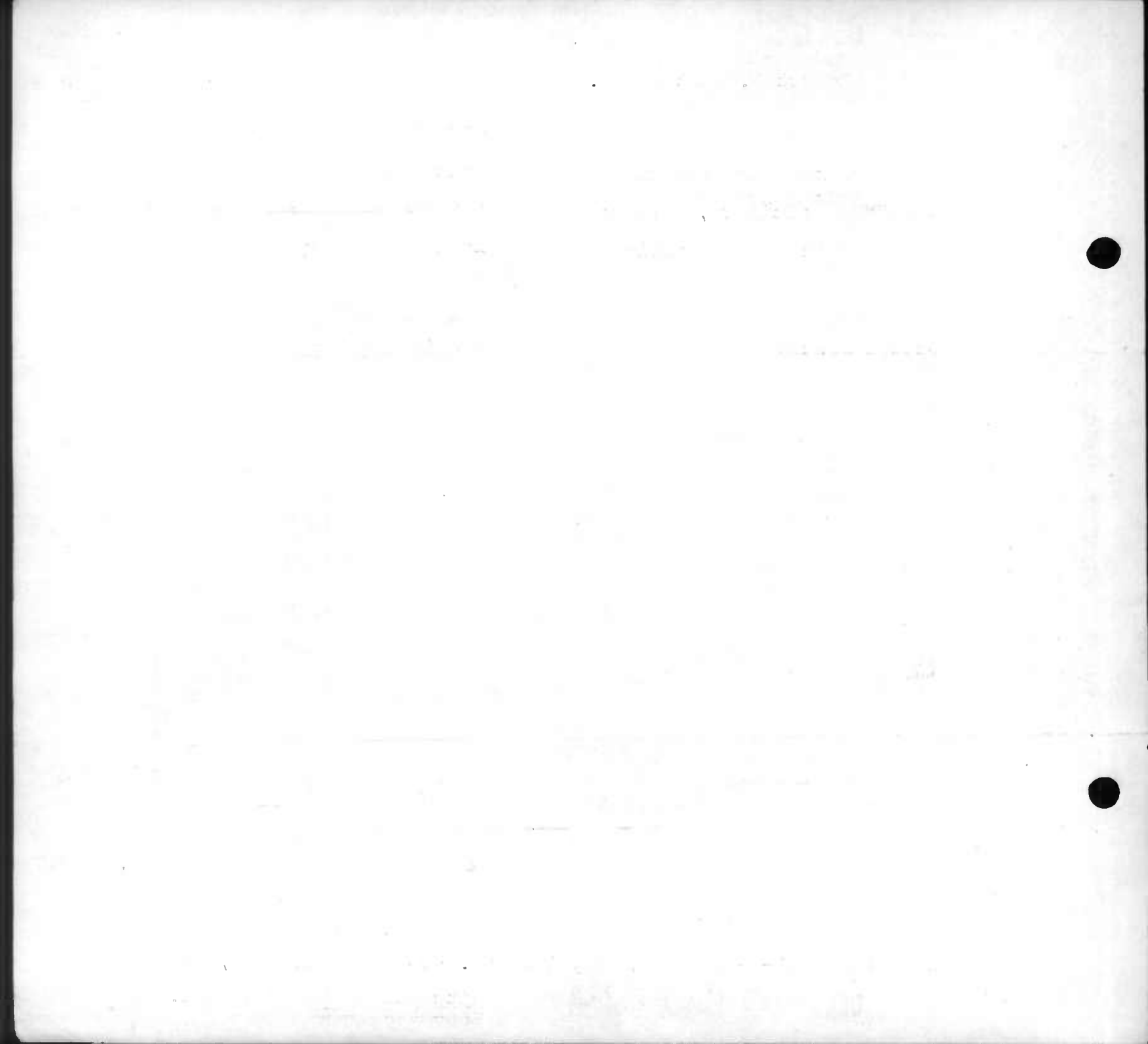
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12518	
BIRTH NO. 65 12518		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Edward H. Schneider		2. DATE AND HOUR OF DEATH Dec. 7, 1965 11 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 27-44			
FULL NAME OF HOSPITAL OR INSTITUTION 3011 Evergreen Ave.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3011 Evergreen Ave.			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH Aug. 5, 1897	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Penna. R. R.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Jacob Schneider			14. MOTHER'S MAIDEN NAME Mary Michael		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 716123483		17. INFORMANT Mrs Anne E. Schneider	
				ADDRESS same	
18. 381.0 I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Hepatic Coma		INTERVAL BETWEEN ONSET AND DEATH 8 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Cirrhosis of Liver with pleural effusion & ascites + bleeding esophageal varices		15 years	
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 1964 to Dec 1965 , that (I) (we) last saw the deceased alive on 10AM, 7 Dec 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas J. Brennan M.D.				23B. DATE SIGNED 7 Dec 1965	
23C. PHYSICIAN'S NAME (Type) Thomas J. Brennan		23D. ADDRESS 5217 Harford Road Balto Md 21214			
24A. BURIAL CREMATION, REMOVAL (Specify) burial	24B. DATE 12-10-65	24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1965		25B. NAME OF REGISTRAR Robert E. Gaffney		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 12519</u>	
BIRTH NO. <u>65 12519</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Robert A. Foster Rev.</u>		2. DATE AND HOUR OF DEATH <u>DECEMBER 6, 1965</u> <u>3 30</u> <u>P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>13-07</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Roland View Towers</u> <u>Roland Avenue</u> <u>Baltimore, Maryland</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>273 Stanmore Road Roland View Towers</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>4-20-88</u>	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>George Foster</u>		14. MOTHER'S MAIDEN NAME <u>Lennie Roudles</u>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>411 X I</u> <u>RHEUMATIC HEART DISEASE</u> <u>WITH AORTIC REGURGITATION</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>45 YRS.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>POSSIBLE ARTERIOSCLEROTIC HEART DISEASE -</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the doctor) attended the deceased from <u>NOVEMBER 1964</u> to <u>DECEMBER 6 1965</u> , that (I) (we) last saw the deceased alive on <u>DECEMBER 2 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Carlton L. Sexton</u>				23B. DATE SIGNED <u>DECEMBER 7, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>CARLTON L. SEXTON</u>		23D. ADDRESS M.D. <u>819 PARK AVE, BALTIMORE, MD. 21201</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>removal</u>		24B. DATE <u>12-6-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Johns Hopkins Med. School Baltimore, Maryland</u>	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Mitchell & Wiedefeld Inc.</u> <u>8888 York Road</u>	



The body of Charles M. Davis was released Non-Med by Dr. Linthicum to
The Johns Hopkins Hospital 12-7-65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 125203</u>	
BIRTH NO. <u>65 12520</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>DAVIS, Charles M.</u>	
2. DATE AND HOUR OF DEATH <u>December 7, 65</u> <u>9:53</u> A.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Johns Hopkins Hospital</u>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Anne Arundel</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Middle River Md.</u> D. STREET ADDRESS (If rural, give location) <u>207 Bourque Rd.</u>		5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Mar.</u> 8. DATE OF BIRTH <u>4/19/02</u> 9. AGE (In years last birthday) <u>63</u> 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Beth. Steel</u> 10B. KIND OF BUSINESS OR INDUSTRY <u>Steel Worker</u> 11. BIRTHPLACE (State or foreign country) <u>W. Va.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Landon Davis</u>		14. MOTHER'S MAIDEN NAME <u>Nannie (Unknown)</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>235-18-2963</u>		17. INFORMANT <u>JBurnis JHH</u> ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		22A. AUTOPSY? (Yes or No) <u>YES No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-7</u> 19 <u>65</u> to <u>12-7-</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12-7</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael A. Davis</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>12-7-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Michael A. Davis</u>				23D. ADDRESS <u>The Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>12/7/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lerona Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Lerona, W.Va.</u>		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
24G. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1965</u>		24H. NAME OF REGISTRAR <u>Wm. Cook-Brooks Inc</u>		24I. FUNERAL DIRECTOR <u>1217 St. Paul St. Baltimore, Md.</u>	

and the ...

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 12521		CERTIFICATE OF DEATH		65 12521	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Steffe Daniel</i>		2. DATE AND HOUR OF DEATH <i>12/4/65 10:30 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Sm. Hospital of Baltimore</i>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>5210 St. Charles Ave</i>	
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>2/25/94</i>	9. AGE (In years last birthday) <i>71</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumber</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Plumbing</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>James H. Steffe</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth V. Martin</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes or no) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-07-9176A</i>		17. INFORMANT <i>Elizabeth Steffe</i> ADDRESS <i>5210 St. Charles Ave</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>420.11</i>		CAUSE OF DEATH (A) <i>Acute MI (?) - accident (?)</i> DUE TO (B) <i>ASCVD</i> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>chronic bronchitis and emphysema</i>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>done</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11/16/65</i> 19 <i>65</i> to <i>12/4/65</i> 19 <i>65</i> , that (I) (we) lost saw the deceased alive on <i>12/4</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>A.G. Coman</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>12/4/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>A.G. Coman</i>		23D. ADDRESS <i>Sinai Hosp. Balto.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>12-8-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Lorraine Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Woodlawn Balto. Md</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 9 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR <i>Loring Byers</i> ADDRESS <i>8728 Liberty Rd Randallstown, Md</i>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 12522		CERTIFICATE OF DEATH		65 12522	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Samuel J. Birely		12-7-65 11:55 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
		Maryland		23-02	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
South Baltimore General Hosp.		Baltimore # 21230		9 E. Wheeling St.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
M.	W.	Married	AUG 24 '99	66	DRY DOCK OPR.
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
Maryland		Maryland		Samuel D. Birely	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Anna EYLER		YES WWI		214-03-2178	
17. INFORMANT		ADDRESS			
MRS MARGARET BIRELY		MRS MARGARET BIRELY			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <u>Arteriosclerotic Cardiovascular Disease</u>			
		(B) <u>Chronic Obstructive Pulmonary Disease</u>			
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
D		No		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
No		No		No	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
No		No		No	
22. I certify that (this hospital) attended the deceased from 11-24 1965 to 12-7 1965, that (we) lost saw the deceased alive on 12-7 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Calvin E. Jones, Jr.		12/8/65		Calvin E. Jones, Jr.	
23D. ADDRESS		23E. FURNERAL DIRECTOR			
South Baltimore General Hospital		JOHN F. DENNY, INC. 715 LIGHT ST.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		12/10/65		CEDAR HILL CEM.	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.			
BALTIMORE, MD.		DEC 9 1965			
24F. NAME OF REGISTRAR		24G. ADDRESS			
JOHN F. DENNY, INC.		715 LIGHT ST.			

10/10/1911
Dear Sir,
I have the pleasure to inform you that the
order for the purchase of the above mentioned
quantity of material has been placed with the
proper authorities and will be forwarded to you
as soon as the same has been received.

Yours faithfully,
J. H. [Signature]

10/10/1911
J. H. [Signature]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. M.E. CASE NO.		65 12523		65 12523	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
EDWARD FRANCIS SHEALEY		Dec. 6, 1965 1:30 p. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
City Hospital		Md. 21224			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		103 N. Kenwood Ave.,			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
male	white	married	9/4/1902	63	Gen. Foreman
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
		Beth. Steel	Baltimore, Md.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Harry S. Shealey			Catherine Kelly		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
			Rose Kolousek Shealey, wife, above		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 & R60X		Coronary Arteriosclerosis		11 yrs	
ANTECEDENT CAUSES		Hypertensive Cardiovascular Disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Diabetes Mellitus		3 yrs.	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 19 54 to 7/7 19 65, that (I) (we) last saw the deceased alive on 7/7 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Dr. Charles J. Blazek			12/8/65		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Dr. Charles J. Blazek			1116 St. Paul Street		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	12/10/65	Oak Lawn Cemetery	Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
DEC 9 1965	Robert E. Taylor	Schimune Funeral Home, Inc.		3331 Briggs Lane	

RECEIVED THE NATIONAL ARCHIVES

BIRTH NO.

65 12524

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 12524

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)Charles
WILLIAM C. HORKY

2. DATE AND HOUR PRONOUNCED DEAD

12/5/65 5:15 p.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

919 N. Patterson Pk. Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married

8. DATE OF BIRTH

1/31/1905

9. AGE (in years
last birthday)

60

10. Under 1 Yr. 11 Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Machinist

10B. KIND OF BUSINESS OR INDUSTRY

C.M. Kemp Mfg. Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Frank Horky

14. MOTHER'S MAIDEN NAME

Petronella Novotny

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

215-10-1134

17. INFORMANT

ADDRESS

Lena Vieweg Horky, wife, above

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Arteriosclerotic cardiovascular disease
(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/7/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/10/65

23C. NAME OF CEMETERY or CREMATORY

Bohemian National Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

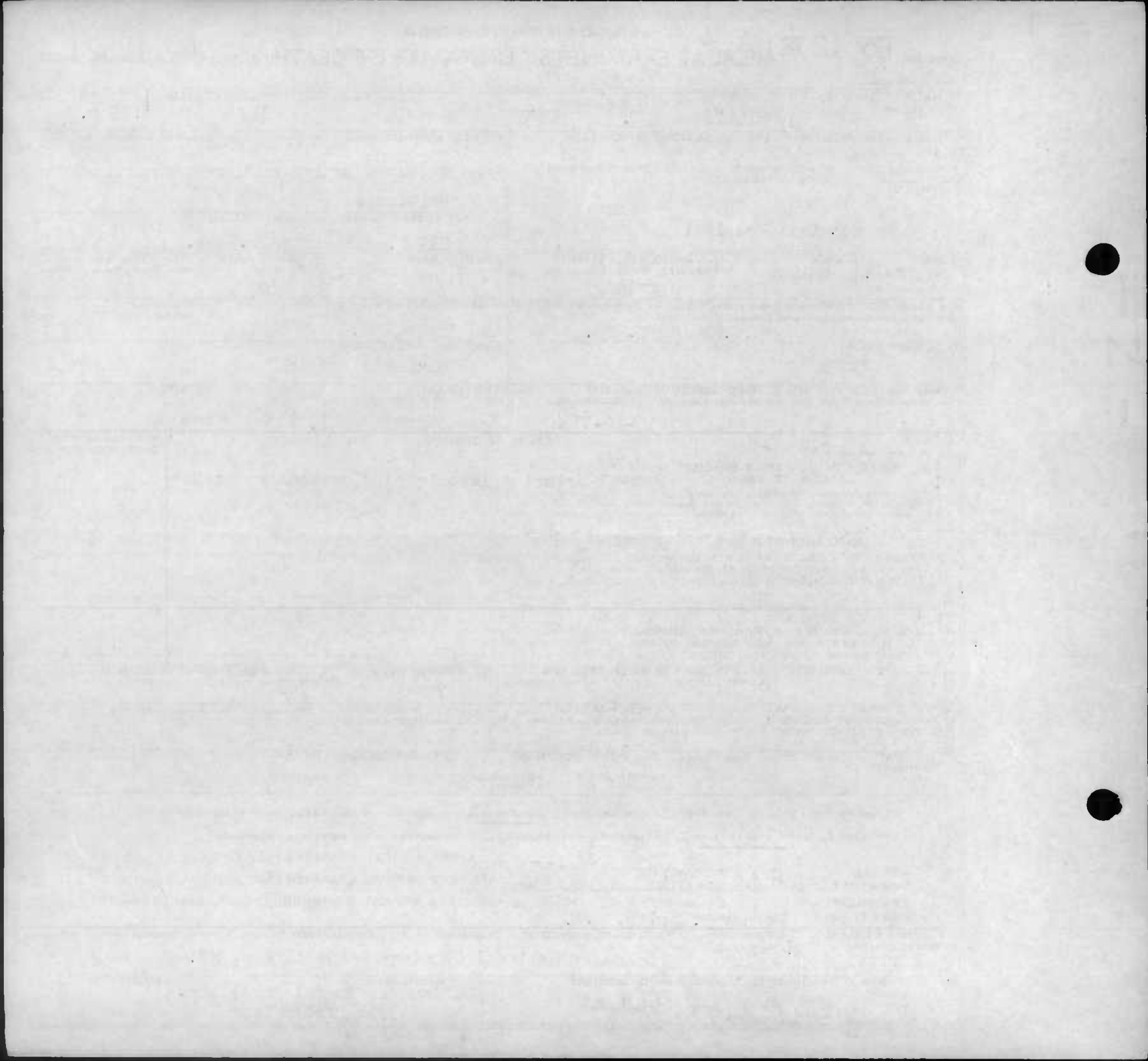
24C. FUNERAL DIRECTOR

ADDRESS

DEC 9 1965

Robert E. Fiedler

Schimunek Funeral Home, Inc.
3331 Brehms Lane



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12525	
BIRTH NO. 65 12525		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CAMPBELL, Walter Alfred		2. DATE AND HOUR OF DEATH 12/6/65 10:55p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
44 Union Memorial Hospital		Baltimore, Maryland		300 Montrose Ave Md 21221	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12/9/11	9. AGE (In years last birthday) 54	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hammer Operator		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore	
13. FATHER'S NAME John Campbell		14. MOTHER'S MAIDEN NAME Ida Johnson		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 212-07-7245		17. INFORMANT wife	
18. 203X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Multiple Myeloma		INTERVAL BETWEEN ONSET AND DEATH 2 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Hyperpyrexia		(B) DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from 12/3/65 19 to 12/6/65 19 that (I) (we) last saw the deceased alive on 12/6/65 19 and that (in) (my) (ap) (of) apinlan death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Godfrey S. Geh		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/6/65	
23C. PHYSICIAN'S NAME (Type) GODFREY S. GEH		23D. ADDRESS Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/10/65		24C. NAME OF CEMETERY or CREMATORY Zion Lutheran	
24D. LOCATION Balto. Co. Md.					
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1965		25B. NAME OF REGISTRAR Robert E. Fadden		25C. FUNERAL DIRECTOR Connolly Sons 300 Montrose Ave. 21	

1170 2-28-2000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 12526</u>	
BIRTH NO. <u>65 12526</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>JOHN JOSEPH MEYERS</u>		2. DATE AND HOUR OF DEATH <u>12-7-65</u> <u>1:45 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE 34</u> <u>53-00</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSPITAL</u>		D. STREET ADDRESS (If rural, give location) <u>2825 TOPAZ ROAD</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>2-10-92</u> <u>73</u>	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ship fitter (ret.)</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>MARTIN MEYERS</u>		14. MOTHER'S MAIDEN NAME <u>RUSATHA EPELSON</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-09-2426</u>		17. INFORMANT <u>CHART</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>163X1</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <u>PNEUMONITIS; 90 PULM. EMBOLUS 12 hrs</u> DUE TO			
		(B) <u>CA (L) LUNG WITH METASTASIS - 6 mos</u> DUE TO			
		(C) <u>(R) MIDDLE CEREBRAL THROM. 6 wks</u>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>May 1965</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CA LUNG</u>		20A. AUTOPSY? (Yes or No) <u>?</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 1</u> 19 <u>65</u> to <u>Dec 7</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Dec 6</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R. S. Stone</u>				23B. DATE SIGNED <u>12-7-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>R. T. STONE</u>		23D. ADDRESS M.D. <u>4202 GREENWAY, 21218</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-10-65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>WESTERN CEM.</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTD MD</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 9 1965</u>		25B. NAME OF REGISTRAR <u>R. E. FARRAR</u>		25C. FUNERAL DIRECTOR <u>G. F. Evans, Sun 8802/Harford Rd</u>	

201

1900

W. 19



BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 12527 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12527

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Knoedler

2. DATE AND HOUR PRONOUNCED DEAD

12/2/65 19:06 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

LILLIAN

KNOEDLER

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1965 Perlman Place

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Hopkins Hospital

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

never married

8. DATE OF BIRTH

Dec 20, 1887

9. AGE (In years
last birthday)

87 78

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Charwomen

10B. KIND OF BUSINESS OR INDUSTRY

Mercantile

11. BIRTHPLACE (State or foreign country)

Portsmouth, New Hampshire

12. CITIZEN OF
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Frank Knoedler

14. MOTHER'S MAIDEN NAME

Lena

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

217-16-7768

17. INFORMANT

Attorney-Avrum K. Rifman

ADDRESS

One Charles Center Balto Md

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Carbon monoxide poisoning

(A) _____
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1965 Perlman Place

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12 2 '65 8:50 PM

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE ☒
AT WORK21F. HOW DID INJURY OCCUR? Rushed into burning
home to rescue pets

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/3/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

N948.0 DEC 9 1965

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

RECEIVED

U.S. DEPT. OF JUSTICE

NAME	LAST FIRST MIDDLE
DATE OF BIRTH	MONTH DAY YEAR
PLACE OF BIRTH	CITY STATE COUNTRY
EDUCATION	SCHOOL GRADE
EMPLOYMENT	NAME ADDRESS CITY STATE COUNTRY
RELIGION	
POLITICAL AFFILIATION	
REMARKS	

1

65 12528

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12528

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Wladyslawa LOTTIE WRZASKA

2. DATE AND HOUR PRONOUNCED DEAD

12-6-65 6:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3322 Fait Avenue 21224

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

January 1904

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

House Wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Kwiatkowski

14. MOTHER'S MAIDEN NAME

Unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Peter Wrzask Husband

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

CHARLES S. PETTY

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-6-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12.8.65

23C. NAME of CEMETERY or CREMATORY

Garden Of Faith

23D. LOCATION

(City, town, or county)

Baltimore

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 9 1965

R. E. F. J. J. J.

Fajewski Funeral Home
Canton Ave.
+ Washington



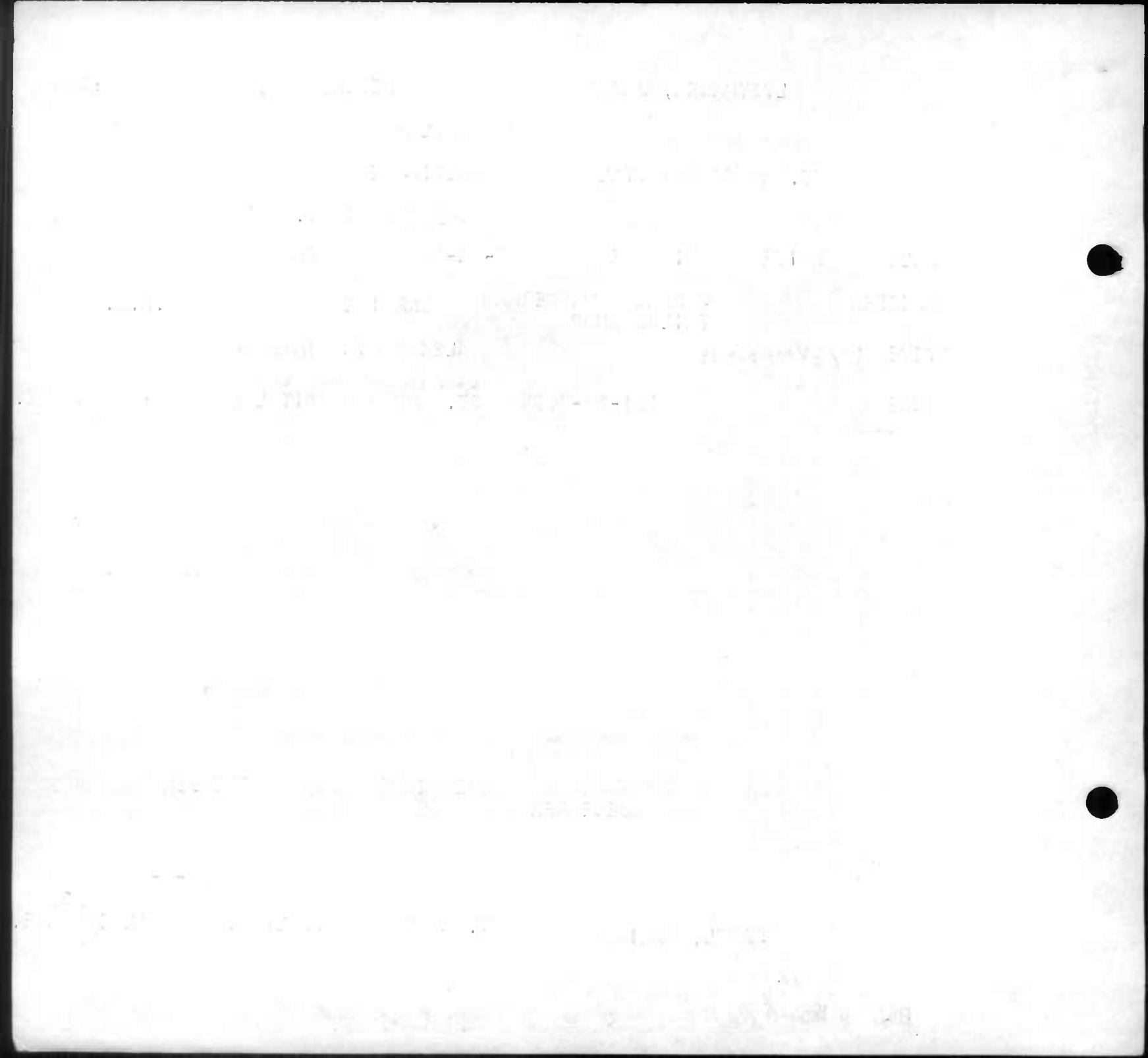
CONFIDENTIAL

U.S. GOVERNMENT PRINTING OFFICE: 1967 O 334

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12529	
BIRTH NO. 65 12529		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LYSYMANKA, JACOB		2. DATE AND HOUR OF DEATH DECEMBER 6, 1965 9:20A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 25-05		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL		D. STREET ADDRESS (If rural, give location) 1603 SPRUCE ST. #26			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED	8. DATE OF BIRTH 5-10-10	9. AGE (In years last birthday) 55	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRESSER		10B. KIND OF BUSINESS OR INDUSTRY CORMAN & WASSERMAN TAILOR SHOP		11. BIRTHPLACE (State or foreign country) UKRAINE	
13. FATHER'S NAME STEVE LYSYMANKA		14. MOTHER'S MAIDEN NAME ALEXANDRIA HALCHSHYN		12. CITIZEN OF WHAT COUNTRY? XXXXXX	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 171-26-7798		17. INFORMANT ROSE LASUK 1018 CHURCH ST. ST. AGNES HOSPITAL RECORDS; CATON AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 420.1 I		CAUSE OF DEATH (A) DUE TO Old and massive recent myocardial infarction - (B) DUE TO Unusualized arteriosclerosis (C) Drug-induced heart failure Early bacterial pneumonia.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 6 1965 to DECEMBER 6 1965 , that (I) (we) lost saw the deceased alive on DECEMBER 6 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-6-65	
23C. PHYSICIAN'S NAME (Type) RAFAEL, MARIN		23D. ADDRESS ST. AGNES HOSPITAL; CATON & WILKENS AVE.		#29	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-10-65		24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cem.	
24D. LOCATION (City, town, or county) (State) Anne Arundel Co. Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 9 1965		25B. NAME OF REGISTRAR Robert E. Fink	
25C. FUNERAL DIRECTOR Wm. Fialkowski		ADDRESS 2007 Eastern Ave. Balto. Md. 21231			



1
K-325

65 12530

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65-12530

BIRTH NO. M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) John Kotchen		2. DATE AND HOUR PRONOUNCED DEAD 12/7/65 10:20 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hosp.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5101 Pennington Ave.	
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH FEB. 10, 1896
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		10B. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	11. BIRTHPLACE (State or foreign country) VIRGINIA
13. FATHER'S NAME MICHAEL KOTCHEN		14. MOTHER'S MAIDEN NAME ELIZABETH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). If yes, give war or dates of service YES W.W. I		16. SOCIAL SECURITY NO. 220-05-2595	17. INFORMANT THOMAS KOTCHEN
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.1 Arteriosclerotic cardiovascular disease DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) no
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/7/65			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial	23B. DATE 12-11-65	23C. NAME OF CEMETERY or CREMATORY Holy Cross Cem.	23D. LOCATION (City, town, or county) (State) Anne Arundel Co. Md.
24A. DATE REC'D BY HEALTH DEPT. DEC 9 1965	24B. NAME OF REGISTRAR Robert E. Fiedler	24C. FUNERAL DIRECTOR W. Fiedler	ADDRESS 2007 Eastern Ave. Balto. Md. 21231

VS 151-REV. 1/1/65

WALLACE FORGE

YES I AM I
120-2-1222 THOMAS MORTIMER
DATE 10-11-10
MILWAUKEE TO TOWN
EL PASO
VIRGINIA
MAY 10 1910
JUN 10 1910

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		65 12531		65 12531	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		TITUS, CHARLES			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		2. DATE AND HOUR OF DEATH December 6, 1965 9 ³² / _A M.			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland Glen Burnie Anne Arundel			
Lutheran Hospital of Maryland Baltimore, Maryland 21216		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Glen Burnie 5200			
		D. STREET ADDRESS (If rural, give location) 116 Janelin Drive			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH December 12, 1913	9. AGE (In years last birthday) 51	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Salesman		Jobbers Supply Co.		Maryland (Balto.)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William G. Titus		Margaret Fiske		U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		219-01 4933		Mrs. Agnes Titus (wife) Same As #2	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
576X I		(A) Hepatic coma			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Generalized toxemia			
		(C) Subhepatic Abscess			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
Nov. 30, 1965		Subhepatic Abscess		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from November 26 1965 to December 6 1965, that (I) (we) last saw the deceased alive on December 6 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 9 ³² / _{AM}					
23A. SIGNATURE Manuel H. Gortanilla		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED December 6, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		Dec. 9/65		London Park	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR ADDRESS			
Baltimore, Maryland		R.V. Singleton Glen Burnie, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 9 1965		R.V. Singleton		Glen Burnie, Md.	

(1941) in the physical sciences
of the human mind
(2) in the social sciences
and in the history of science

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

65 12532

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 12532

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CARLTON W. SISSON

2. DATE AND HOUR PRONOUNCED DEAD

12-6-65

9:55 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

MARYLAND GENERAL HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1323 N. Calvert Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

Nov. 8, 1898

9. AGE (In years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unknown

10B. KIND OF BUSINESS OR INDUSTRY

Unknown

11. BIRTHPLACE (State or foreign country)

Millersville Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Carlton W. Sisson

14. MOTHER'S MAIDEN NAME

Helen M. Woodward

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

YES

W.W.I

16. SOCIAL
SECURITY NO.

Unknown

17. INFORMANT

ADDRESS

Mrs. Eleanor W. Coggins (sister) Same As #4

18.

330X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Massive subarachnoid and intracerebral
~~hemorrhage~~

hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) DUE TO Rupture, aneurysm of anterior
communicating artery

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

CHARLES S. PETTY

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-6-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Dec. 10/65

23C. NAME of CEMETERY or CREMATORY

Baldwin Mem. Cem.

23D. LOCATION (City, town, or county)

Millersville, Maryland

24A. DATE REC'D BY HEALTH DEPT.

DEC 9 1965

24B. NAME OF REGISTRAR

Robert E. Johnson

24C. FUNERAL DIRECTOR

R. W. Singleton, Glen Burnie, Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12533		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12533	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MATTHEW E. MURPHY			2. DATE AND HOUR OF DEATH 12-8-65 12:20 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION University			A. STATE MARYLAND B. COUNTY Anne Arundel		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) N. LINTHICUM 5200		
			D. STREET ADDRESS (If rural, give location) 7. S. ANNAPOLIS RD		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11-25-93	9. AGE (In years last birthday) 72	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glass worker (Ret.)		10B. KIND OF BUSINESS OR INDUSTRY Md. Glass Co.-		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME THOMAS E MURPHY			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-10-6010		17. INFORMANT Mrs. Sarah Ann Murphy (wife) Same As Hospital Adm Sheet
18. 400.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION 2 DAYS			INTERVAL BETWEEN ONSET AND DEATH 2 DAYS		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. HYPOTHYROIDISM			9 YEARS		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 0		20A. AUTOPSY? (Yes or No) 0	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 0		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 0		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 0	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 0		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> 0		21F. HOW DID INJURY OCCUR? 0	
22. I certify that (H) (this hospital) attended the deceased from 12-6 1965 to 12-8 1965, that (H) (we) last saw the deceased alive on 12-8-65 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (not) view the body after death.					
23A. SIGNATURE Henry Allan Saiontz				23B. DATE SIGNED 12-8-65	
23C. PHYSICIAN'S NAME (Type) Henry Allan Saiontz				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 11/65		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Brooklyn, RFD, Md.					
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1965		25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR R. Singleton	
				ADDRESS Glen Burnie, Md.	

5536

65 12534		BALTIMORE CITY HEALTH DEPARTMENT		65 12534	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
BIRTH NO.					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD			
JAMES SANDERS		December 7, 1965 7:25 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
Sinai Hospital		Maryland			
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		5508 Peerless Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
male	negro	MARRIED	Jan-24-25	40	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
SOLDIER		U.S.-A.-A.-F.		SOUTH CAROLINA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
HUBERT SANDERS		Lillie Byrd		USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES				LVA SANDERS 5508 PEERLESS AVE	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Amyotrophic lateral sclerosis			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22.		I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		12-8-65	
Rudiger Breitenecker, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY	
REMOVAL		12/9/65		Not Monish	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
DEC 9 1965		Robert E. Fadden		Marshall P. Hays 638 N. G. L. m. or st	

WALLINGTON

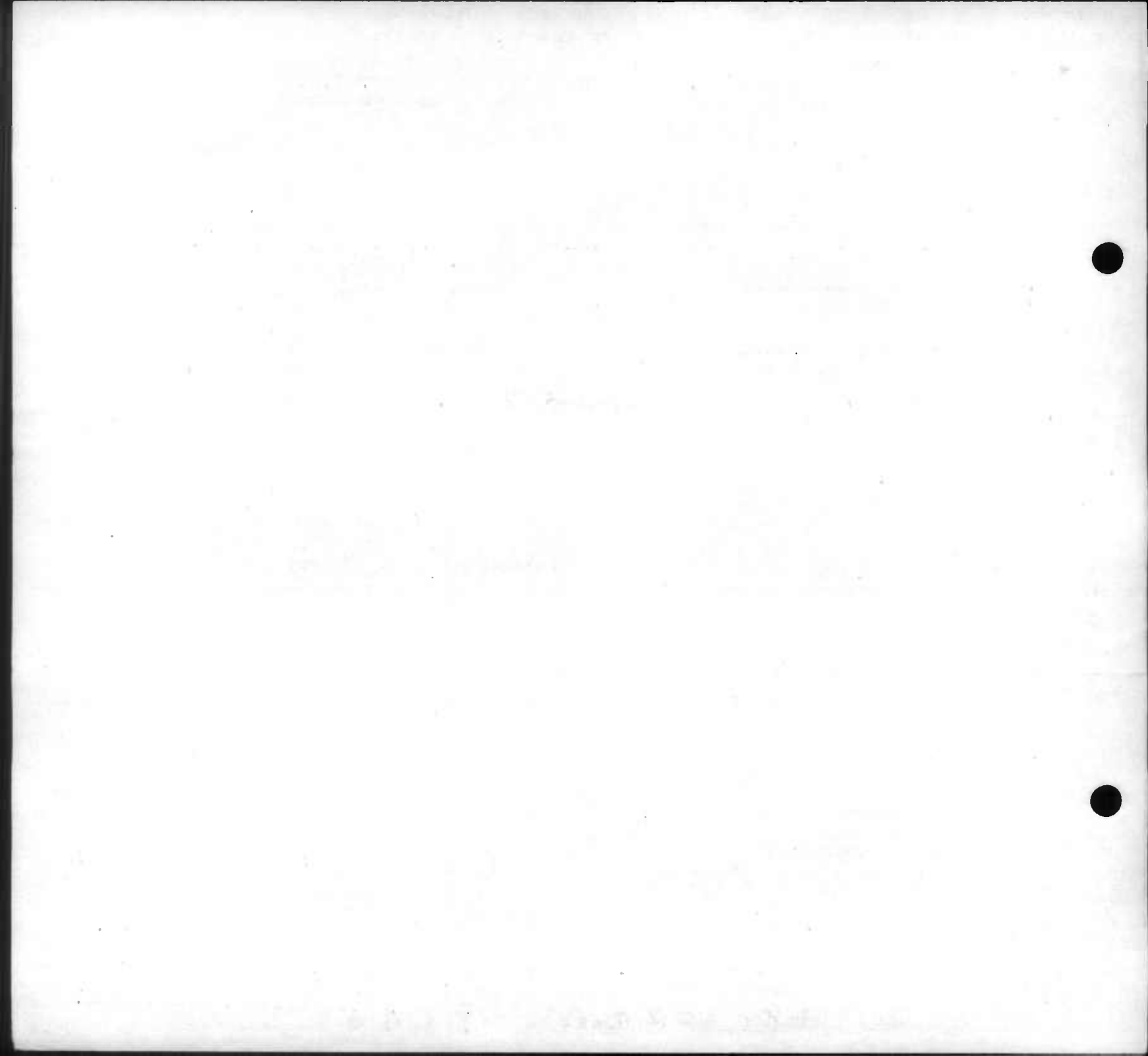
PAID OFF

W. J. Wallington

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

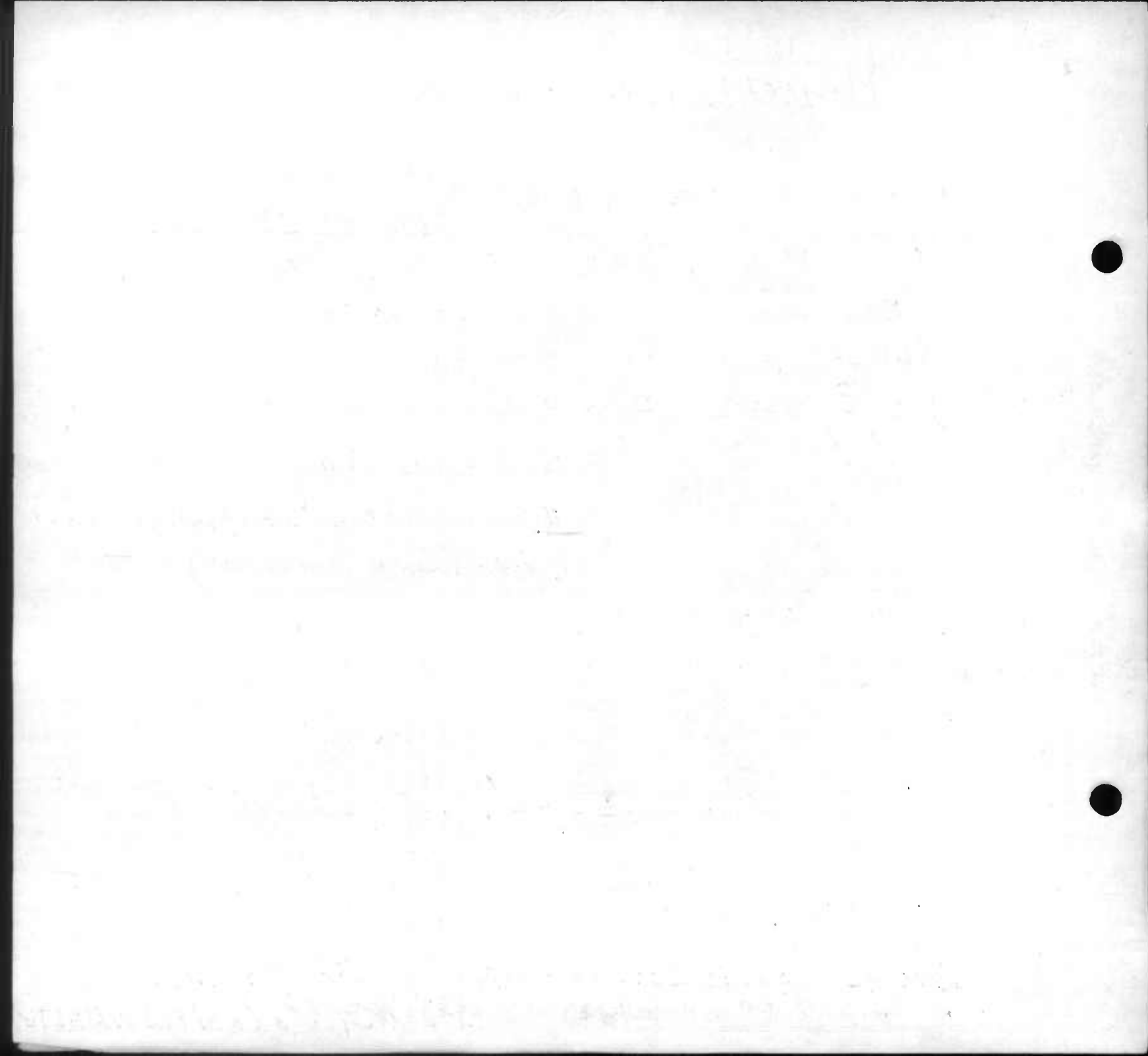
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12535	
BIRTH NO. 65 12535		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Edward C. Tompkins		2. DATE AND HOUR OF DEATH Dec. 6, 1965	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 20-05			
FULL NAME OF HOSPITAL OR INSTITUTION 504 East Lynn Ave		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 504 East Lynn Ave.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Nov. 29, 1897	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repairman		10B. KIND OF BUSINESS OR INDUSTRY Oil Burners		11. BIRTHPLACE (State or foreign country) District of Columbia	
13. FATHER'S NAME Percy Tompkins		14. MOTHER'S MAIDEN NAME Julie Thompson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-10-5376		17. INFORMANT Mrs. Mary Tompkins	
				ADDRESS Same	
18. 3 02.01		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Cardio Respiratory failure			
ANTECEDENT CAUSES		(B) DUE TO Pulmonary emphysema			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Chronic Bronchitis			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1963 to 6 Dec 1965 , that (I) (we) last saw the deceased alive on 6 Dec 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William J. Bryson				23B. DATE SIGNED 7 Dec 65	
23C. PHYSICIAN'S NAME (Type) Dr. William Bryson				23D. ADDRESS 4605 Edmondson Ave Baltimore, Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-9-65		24C. NAME OF CEMETERY or CREMATORY Mt. Olivet	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1965		25B. NAME OF REGISTRAR Fred A. Cole		25C. FUNERAL DIRECTOR 1915 W. Baltimore St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12536				CITY HEALTH DEPT.		CERTIFICATE OF DEATH		Registered No.	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				MALINOWSKY, Mr. WARREN HENRY		12-7-65 4 30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY			
				MARYLAND		20-05			
MONTEBELLO STATE HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE			
				D. STREET ADDRESS (If rural, give location)		311 S. SMALLWOOD ST.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 10-30-1920	9. AGE (In years last birthday) 45	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RUDOLF MALINOWSKY				14. MOTHER'S MAIDEN NAME ANNIE CROFOOT					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes II-33888342				16. SOCIAL SECURITY NO. 215-14-0280		17. INFORMANT MRS NORMA MALINOWSKY		ADDRESS 311 S. SMALLWOOD ST.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) GENERALIZED CARCINOMATOSIS (SEVERAL MONTHS)				19. CAUSE OF DEATH (A) DUE TO UNDIFFERENTIATED CARCINOMA OF NASOPHARYNX		INTERVAL BETWEEN ONSET AND DEATH 3 YEARS			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, (C) (PARAPLEGIA DUE TO A) -									
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
21A. DATE OF OPERATION 0		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		22A. AUTOPSY? (Yes or No) No		22B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No			
21C. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21E. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21F. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21G. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21H. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 11-18-1965 to 12-7-1965, that (I) (we) last saw the deceased alive on 12-7-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Zin U. Park				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-7-65			
23C. PHYSICIAN'S NAME (Type) Zin U. Park				23D. ADDRESS MONTEBELLO STATE HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-10-65		24C. NAME OF CEMETERY or CREMATORY LOUPON PARK		24D. LOCATION (City, town, or county) (State) BALTO., MD.			
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1965		25B. NAME OF REGISTRAR R. E. Taylor		25C. FUNERAL DIRECTOR Ed. A. Cole		ADDRESS 1913 W BALTO.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65-30819				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12537	
M.E. CASE NO. 65 12537				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Baby boy Matthews</u>				2. DATE AND HOUR OF DEATH <u>12-7-65</u> <u>15 35</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>15-03</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bow Secares Hospital</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO.</u> <u>17</u>			
				D. STREET ADDRESS (If rural, give location) <u>1526 N. PULASKI ST.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>—</u>	8. DATE OF BIRTH <u>12-6-65</u>	9. AGE (In years last birthday) <u>7</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Rome B. Matthews</u>				14. MOTHER'S MAIDEN NAME <u>DOROTHY L. HILLIARD</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>762.51</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) <u>Immaturity</u> DUE TO (B) <u>Cong. Pleuro-pneumonia</u> DUE TO (C) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12/6</u> 19 <u>65</u> to <u>12/7</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12/7</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Chung K. Bae</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12/7/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Chung K. Bae</u>				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12, 8, 65</u>		24C. NAME of CEMETERY or CREMATORY <u>Mid. Auburn</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore 2120 Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 9 1965</u>		25B. NAME OF REGISTRAR <u>P. E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Althia L. McCum</u>		ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

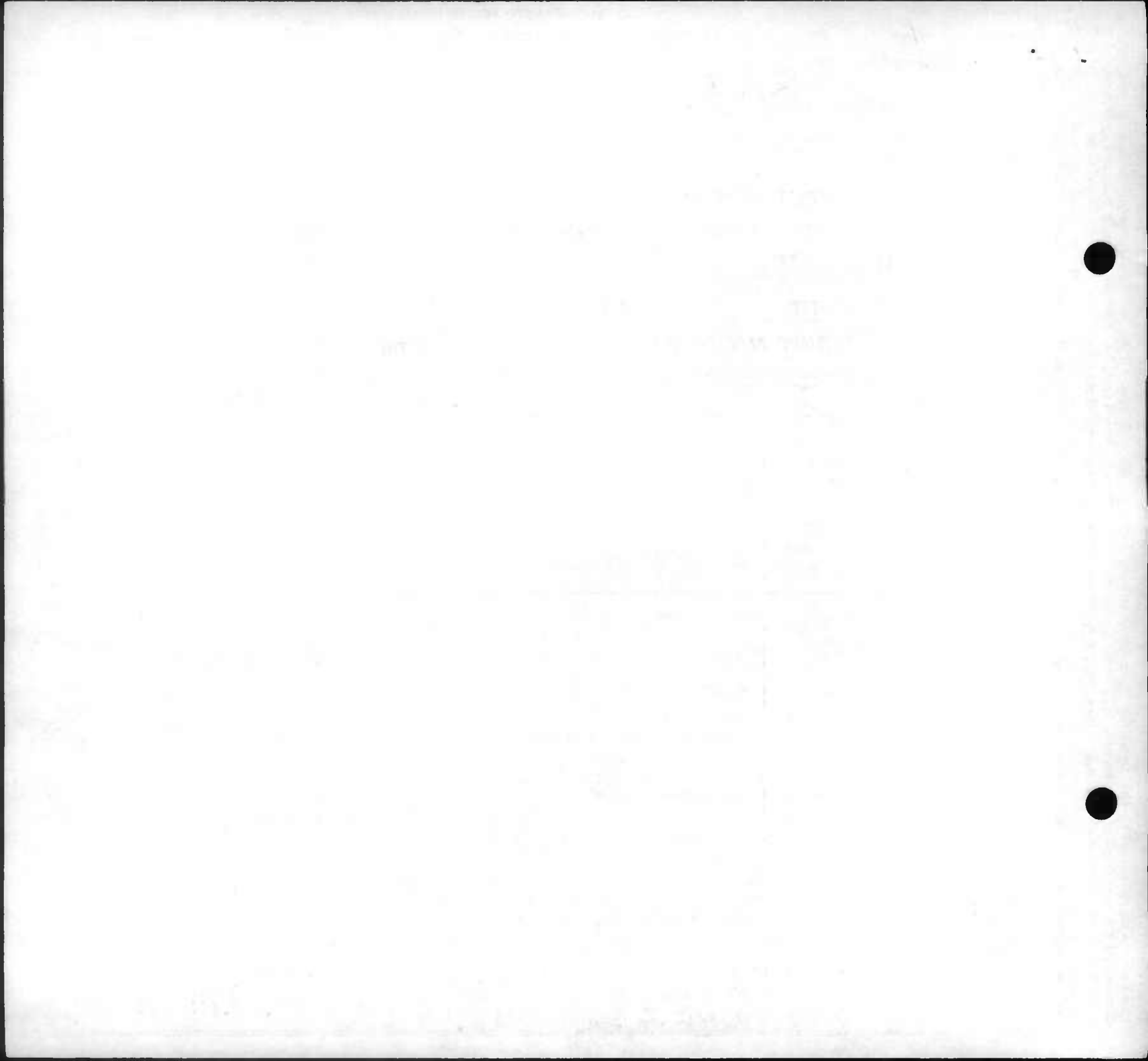
BIRTH NO.		65 12538		CITY OF BALTIMORE HEALTH DEPARTMENT		Registered No. 65 12538	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) HOPE EDWARD JOSEPH				2. DATE AND HOUR OF DEATH 12/6/65 11:30 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2004			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 208 PULASKI ST.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 2/25/20	9. AGE (In years last birthday) 45	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WEIGHT INSPECTOR		10B. KIND OF BUSINESS OR INDUSTRY GRAIN ELEVATOR		11. BIRTHPLACE (State or foreign country) MASS		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME HOPE, EDWARD F. (D)				14. MOTHER'S MAIDEN NAME ANNA (P) (D)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE.		17. INFORMANT WIFE ROSE C. HOPE		ADDRESS SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 330X1				CAUSE OF DEATH (A) Cerebro-vascular accident DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				(B) Rupture of an aneurysm of DUE TO			
				(C) the right anterior cerebral artery.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertension				Pneumonia			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/5 1965 to 12/6 1965, that (I) (we) last saw the deceased alive on 12/5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Charles W. Brown				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/6/65	
23C. PHYSICIAN'S NAME (Type) CHARLES W. BROWN				23D. ADDRESS M.D. UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-9-65		24C. NAME OF CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1965		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR Geo. F. Schrab Funeral Home Address: 2101 Frederick Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

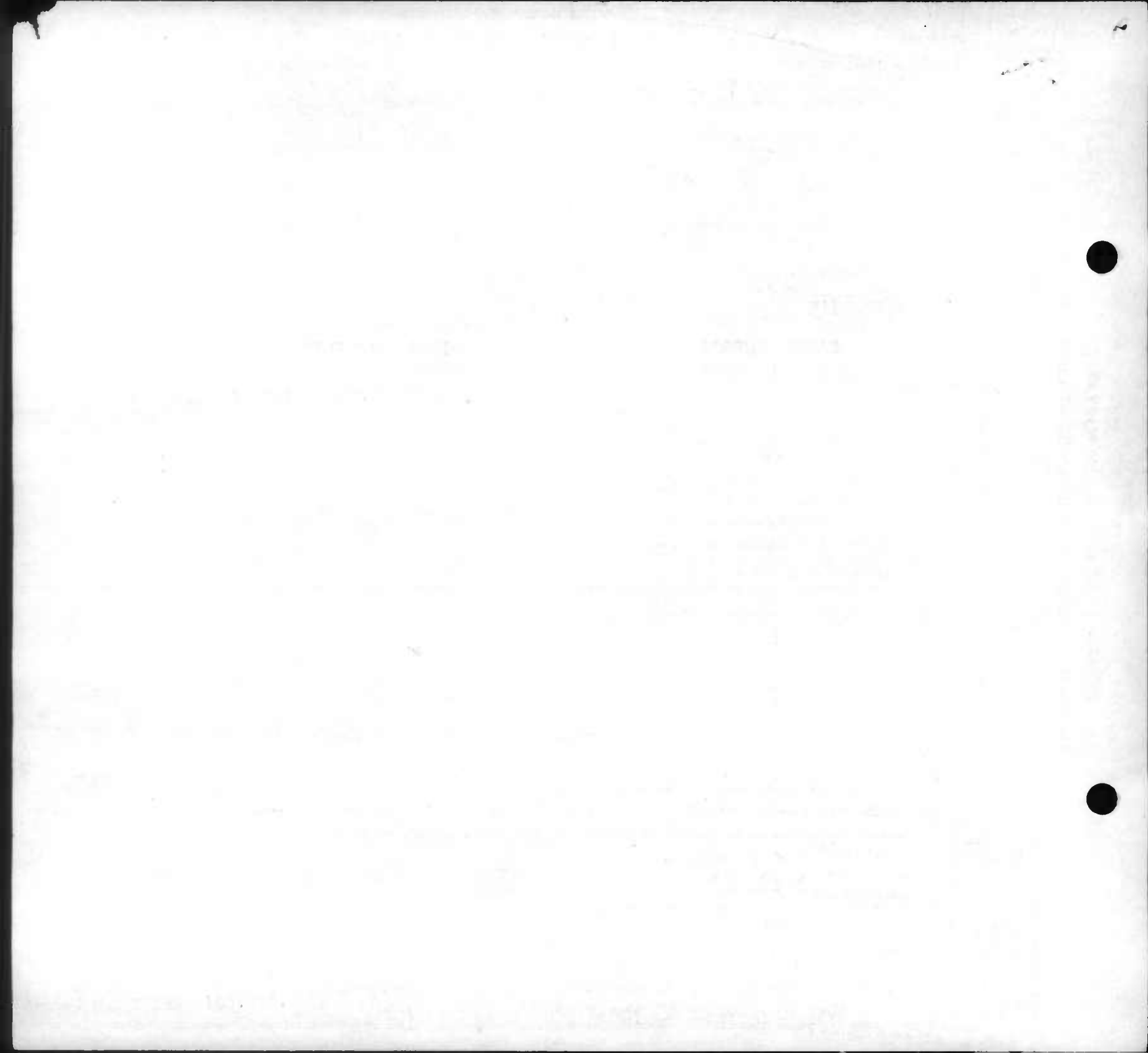
BIRTH NO. 65 12539				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12539	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) RAE NASDOR				2. DATE AND HOUR OF DEATH 12-7-65 1:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 13-04			
5. SEX FEMALE 6. RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED				8. DATE OF BIRTH 79		9. AGE (In years last birthday) 79	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) POLAND	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME BERNARD ZARAMBOWITZ			
14. MOTHER'S MAIDEN NAME ESTHER ?				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.				17. INFORMANT MRS. MILDRED NASDOR ADDRESS 3504 WOODBROOK AVE			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ASCVD				INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypokalemia, CHF (chronic), and sarco			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12-5-1965 to 12-7-1965 , that (I) (we) last saw the deceased alive on 12-7-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M. F. SAIONTZ M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 12-7-65			
23C. PHYSICIAN'S NAME (Type) M. F. SAIONTZ M.O.				23D. ADDRESS Sinai Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/8/65		24C. NAME OF CEMETERY or CREMATORY BETH YEHUDA ANSHE KURLANDER		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1965		25B. NAME OF REGISTRAR REUBEN J. JONES		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC.		ADDRESS 6010 REISTERSTOWN RD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. <u>65 12540</u>	
BIRTH NO. <u>83485 12540</u>		CERTIFICATE OF DEATH					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Tabman, Rose</u>		2. DATE AND HOUR OF DEATH <u>12/7/65</u> <u>2:40</u> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>27-11</u>					
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		D. STREET ADDRESS (If rural, give location) <u>2622 Cyloburn Ave.</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>widowed</u>	8. DATE OF BIRTH <u>9/30/1921</u>	9. AGE (In years last birthday) <u>44</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BARRY BURKOM</u>			14. MOTHER'S MAIDEN NAME <u>MINNA GOLDSTEIN</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MR. BARRY TOBMAN</u>			
				ADDRESS <u>2622 CYLBURN AVE</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>420.1 I Pulmonary embolism + acute MI</u>		CAUSE OF DEATH (A) DUE TO <u>ASCVD</u> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>05</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>11/17</u> 19 <u>65</u> to <u>12/7</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12/7</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Leonard J. Hertzberg</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12/7/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Leonard J. Hertzberg</u>				23D. ADDRESS <u>Sinai Hosp. Baltimore</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12/8/65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>BETH ISRAEL</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 9 1965</u>		25B. NAME OF REGISTRAR <u>R. J. ...</u>		25C. FUNERAL DIRECTOR & ADDRESS <u>SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12541		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 12541	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GERTRUDE CRAWFORD STONE		2. DATE AND HOUR OF DEATH 12-7-65 10:40 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY BALTO.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSP. OF BALTO., INC. BELVEDERE & GREENSPRING		D. STREET ADDRESS (If rural, give location) 3413 MENLO DR. # 15			
5. SEX F	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-22-1908	9. AGE (In years last birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) MASSACHUSETTS	
12. CITIZEN OF WHAT COUNTRY? AMERICAN		13. FATHER'S NAME HARRY KAPLAN		14. MOTHER'S MAIDEN NAME NETTIE STEINBERG	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MR. JACK STONE 3713 MENLO DRIVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CARCINOMA, THYROID, C. GENERAL- LIKED METASTASIS (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION DEC. 7, 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CEREBRAL METAS- TASIS, THYROID CARCINOMA		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from NOV. 26, 1965 to DEC. 7, 1965, that (I) (we) last saw the deceased alive on DEC. 7, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. Bañez		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-7-65	
23C. PHYSICIAN'S NAME (Type) HAWTHORNE N. BANEZ		23D. ADDRESS M.D. SINAI HOSP. OF BALTO.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/10/65		24C. NAME OF CEMETERY or CREMATORY BALTIMORE HEBREW	
24D. LOCATION (City, town, or county) (State) REISTERSTOWN, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS SPL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD	

65 12542

BALTIMORE CITY HEALTH DEPARTMENT

65 12542

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MICHAEL ADDISON LAUER

2. DATE AND HOUR PRONOUNCED DEAD

12-5-65

8:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

305 Newberg Avenue 21228

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

August, 18, 1952

9. AGE (In years
last birthday)

13

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Schoolboy

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph J. Lauer

14. MOTHER'S MAIDEN NAME

Frances Fowler

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

Joseph J. Lauer. 305 Newburg Ave.

Catonsville
Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

E 936.0

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) ~~DEATH~~

Asphyxia by ligature - partial

suspension by loop of rope around
throat

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Basement washroom

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

305 Newberg Avenue

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

12 5 '65 PM

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒21F. HOW DID INJURY OCCUR? Found unconscious -
partial suspension by loop of rope

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-6-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Dec. 9, 1965

23C. NAME OF CEMETERY or CREMATORY

Baltimore, National

23D. LOCATION

(City, town, or county)

Baltimore, Maryland.

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 9

1965

24B. NAME OF REGISTRAR

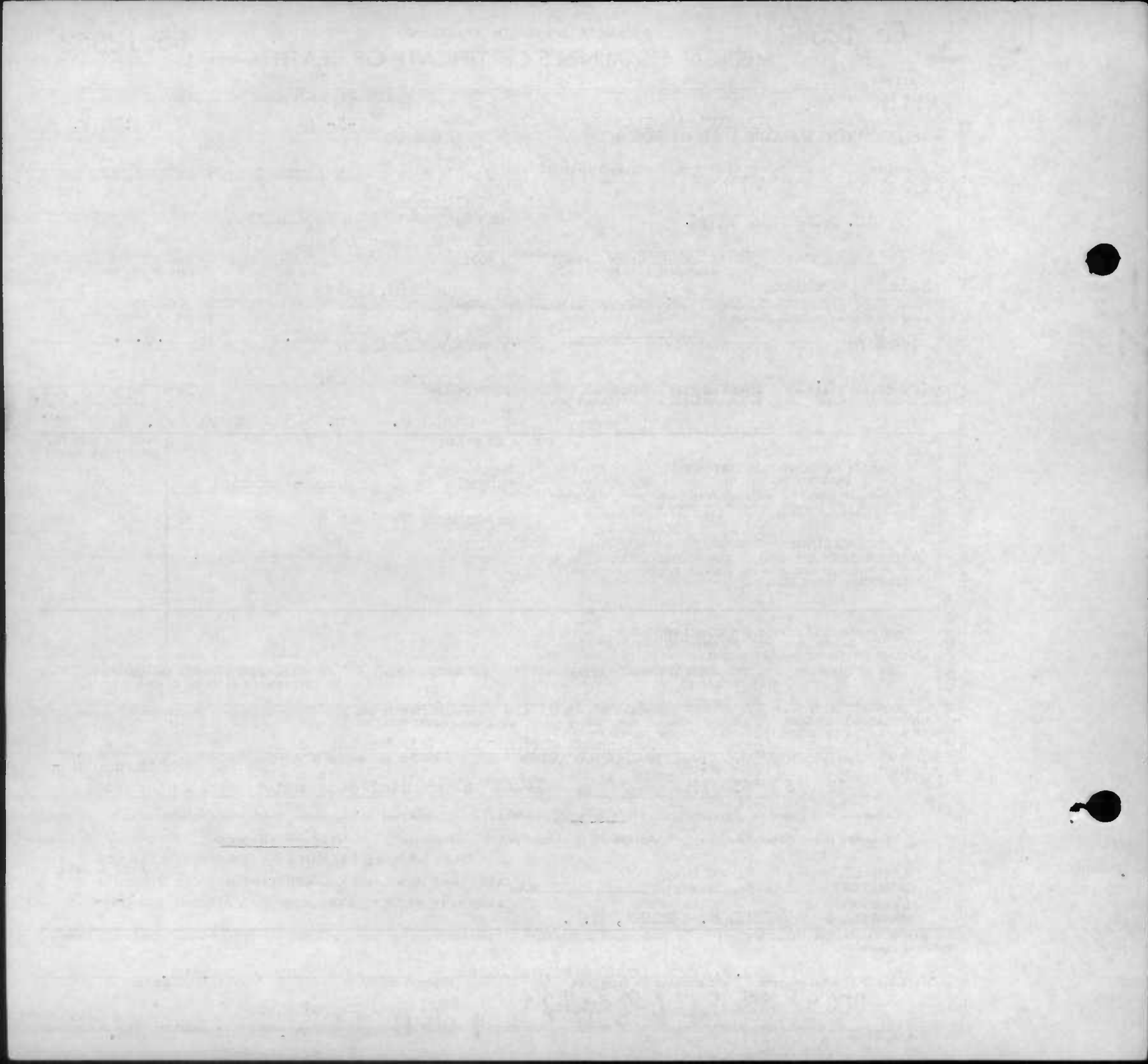
Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Sterling Funeral Estate

ADDRESS

1736 Edmondson Ave. Catonsville, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
65 12543		CERTIFICATE OF DEATH		12543	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <u>Grant, James</u>		2. DATE AND HOUR OF DEATH <u>12/7/65</u> <u>11 A</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u>		A. STATE <u>MD.</u> B. COUNTY <u>16-01</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
		D. STREET ADDRESS (If rural, give location) <u>818 N. FREMONT AVE</u>			
5. SEX <u>M</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>12/31/97</u>	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GAMBLER</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>S. C.</u>	
13. FATHER'S NAME <u>BEE GRANT</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE ?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKN</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Azalee Grant</u>	
				ADDRESS <u>same</u>	
18. <u>138.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>PULMONARY FIBROSIS</u> ANTECEDENT CAUSES (B) <u>SARCOIDOSIS</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (C) _____		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>5 YRS</u> <u>5 YRS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>NONE</u>					
19A. DATE OF OPERATION <u>2 NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NONE</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>NONE</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>APRIL 3, 1962</u> to <u>DEC 7, 1965</u> , that (I) <u>yes</u> last saw the deceased alive on <u>DEC 7, 1965</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>yes</u> (did) <u>did not</u> view the body after death.					
23A. SIGNATURE <u>Wilmot C Ball Jr</u>				23B. DATE SIGNED <u>12/7/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>WILMOT C. BALL JR.</u>				23D. ADDRESS <u>Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-12-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Rural Cemetery</u>	
24D. LOCATION <u>Spoutensburg</u>		24E. (City, town, or county) <u>S. C.</u>		24F. (State) <u>S. C.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 9 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR <u>104-13</u> <u>Farrall Home - N. Arlington Ave</u>	

THE UNIVERSITY OF

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65 12544

BALTIMORE CITY HEALTH DEPARTMENT

65 12544

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

SAMUEL

WINSTON

2. DATE AND HOUR PRONOUNCED DEAD

December 5, 1965

11:15 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

327 W. Biddle Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

327 W. Biddle Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

?

8. DATE OF BIRTH

6/4/00

9. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Emma Hawkins 327 W Biddle St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
12/5/6523A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Burial

12/8/65

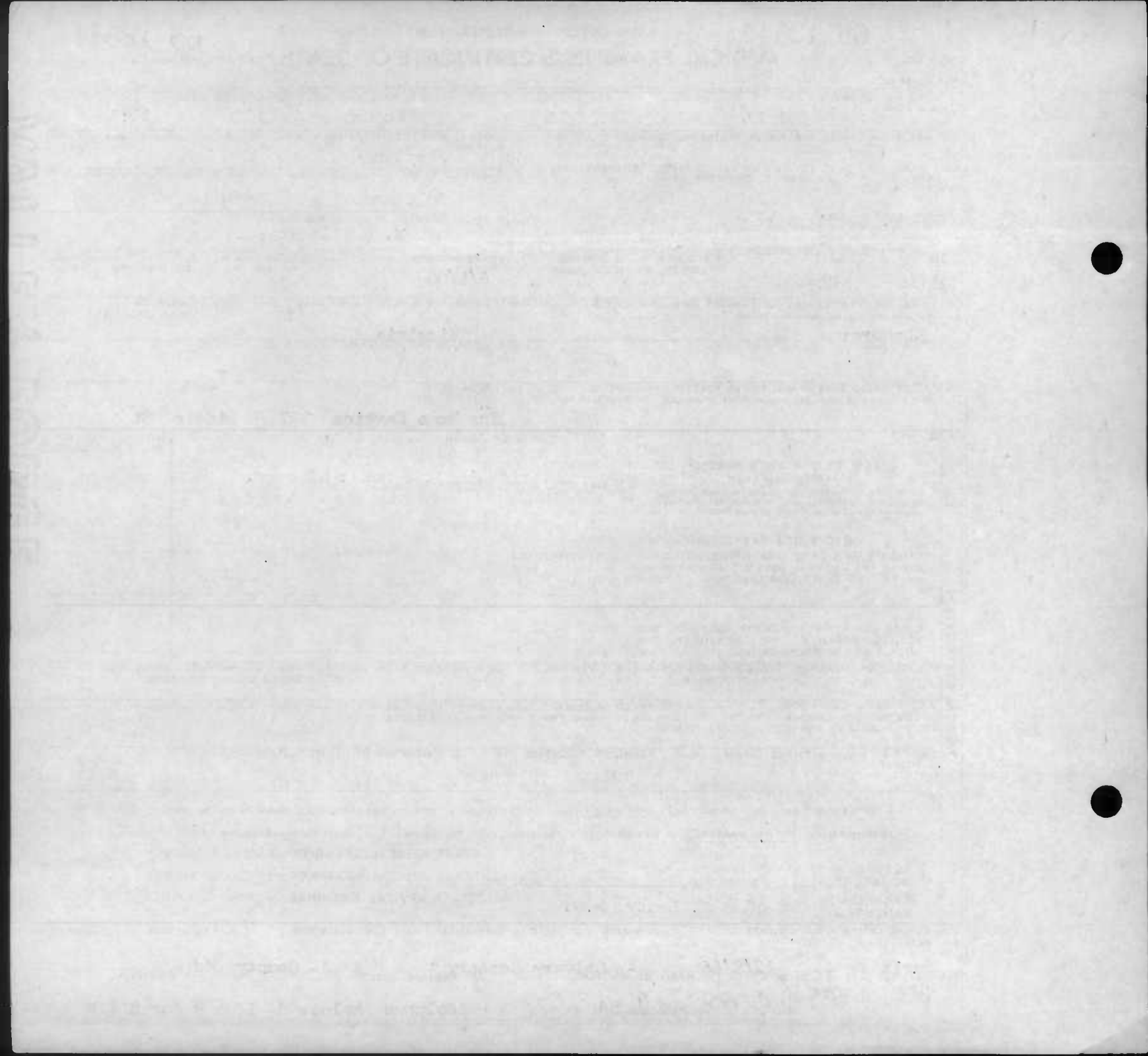
Mt Calvary Cemetery

A A County Md

DEC 9 1965

Robert E. Fadden

Adolphus Halstead 1206 W North Ave



45-22-90
JJ

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12545	
BIRTH NO. 65 12545				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) WILLIAM LASSITER				12-4-65 9:50A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				A. STATE MARYLAND B. COUNTY 18-02	
5. SEX MALE 6. RACE NEGRO 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) DIVORCED				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				D. STREET ADDRESS (If rural, give location) 1212 FAYETTE ST. WEST	
10B. KIND OF BUSINESS OR INDUSTRY				8. DATE OF BIRTH 3-1916 9. AGE (In years last birthday) 49	
11. BIRTHPLACE (State or foreign country) N. CAROLINA				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME Mr Herbert Lassiter 700 Locust St	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 245-20-5397	
17. INFORMANT ADDRESS RECORDS: BCH 4940 EASTERN AVE. #21224					
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Ca lung c Metastases				INTERVAL BETWEEN ONSET AND DEATH Months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from Nov 17 19 65 to Dec 4 19 65 , that (1) (we) last saw the deceased alive on Dec 4 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE K. R. Tucker M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 12/4/65	
23C. PHYSICIAN'S NAME (Type) K. R. Tucker				23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12/8/65	
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery				24D. LOCATION Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1965				25B. NAME OF REGISTRAR Robert E. Fadden	
25C. FUNERAL DIRECTOR Adolphus Halstead				ADDRESS 1206 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in Baltimore and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12546				BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. 65 12546	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) LIZZIE McCain				2. DATE AND HOUR OF DEATH 12/7/65 11:37 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 10-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 911 EAST MADISON STREET			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 2-4-1901	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Fletcher Lomax			14. MOTHER'S MAIDEN NAME Unknown				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Margaret Harris 1005 Alexander Ave.		
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) HEARTDIAE ARREST DUE TO (B) HAS CVD DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 HRS. 15-20 HRS.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>(1)</u> (this hospital) attended the deceased from 12/7/65 19 to 12/7 19 65 , that <u>(1)</u> (we) last saw the deceased alive on 12/7 19 65 and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>(1)</u> (We) <u>(did)</u> (did not) view the body after death.							
23A. SIGNATURE Ashley T. Haase M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/7/65	
23C. PHYSICIAN'S NAME (Type) ASHLEY T. HAASE				23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 12-9-1965		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) Reidsville, N.C.	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1965		25B. NAME OF REGISTRAR 66-5001		25C. FUNERAL DIRECTOR ADDRESS Arlington S. Phillips 1727 N. Monroe St.			

WILLIAM H. HARRIS

1929

1929

WILLIAM H. HARRIS
1929

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 12547	
BIRTH NO. 25-2 65 12547		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Henry Hawkins		2. DATE AND HOUR OF DEATH December 6, 1965 4:30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3001 Cherryland Road 21225			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10-4-1901	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Richard Hawkins				14. MOTHER'S MAIDEN NAME Cola			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224			
18. 443 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) DUE TO CVA (B) DUE TO Hypertension (C) DUE TO ASCVD INTERVAL BETWEEN ONSET AND DEATH 8h ? ? ?							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. R inguinal hernia							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPRDX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/6 1965 to 12/6 1965, that (I) (we) last saw the deceased alive on 12/6 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Clayton L. Moravec, Jr.				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/6/65	
25C. PHYSICIAN'S NAME (Type) Dr. Clayton Moravec				23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/10/65		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) Anne Arundel Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1965		25B. NAME OF REGISTRAR R. E. A. B. Jones		25C. FUNERAL DIRECTOR Clayton L. Moravec		25D. ADDRESS 1727 N. Maryland	

Chas. J. May Jr.

FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <u>65 28808</u>		65 12548		CERTIFICATE OF DEATH		Registered No. <u>65 12548</u>	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Baby William Sterling</u>				November 22, 1965 5:50 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland</u>				A. STATE <u>Maryland</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>2605 Fairview Avenue</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <u>11-21-65</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Sterling</u>				14. MOTHER'S MAIDEN NAME <u>Brown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. <u>762.51</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Respiratory Distress syndrome</u> (B) <u>Pulmonary Atelectasis</u> (C) <u>Immaturity</u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>November 21, 1965</u> to <u>November 22, 1965</u> , that (I) (we) last saw the deceased alive on <u>November 22, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Vincent Blake M.D.</u>				23B. DATE SIGNED <u>November 30, 1965</u>			
23C. PHYSICIAN'S NAME (Type) <u>Dr. Vincent Blake</u>				23D. ADDRESS <u>1514 Division Street</u> <u>Baltimore, Maryland</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>DEC 6 1965</u>		24B. NAME OF CEMETERY OR CREMATORY		24C. LOCATION (City, town or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 9 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>UNIVERSITY MEDICAL SCHOOL</u> <u>MORTUARY SERVICE - BCHD</u>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. <u>65-29115</u> <u>65</u> <u>12549</u>		CERTIFICATE OF DEATH		Registered No. <u>65</u> <u>12549</u>	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				Baby of Annie Faust		November 22, 1965		3:55 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY			
Provident Hospital 1514 Division Street Baltimore, Maryland				Maryland		14-02			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore			
				D. STREET ADDRESS (If rural, give location)		503 Wilson Street			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		Negro				November 22, 1965		48	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
						Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Frank Faust				ANNE E FAUST					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
				(A) DUE TO Neonatal death due to Cerebral Hypoxia					
				(B) DUE TO					
				(C) DUE TO					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2				Yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from November 22, 1965 to November 22, 1965 that (I) (we) last saw the deceased alive on November 22, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Jon B. Corvera, M.D.				November 30, 1965					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
Dr. Corvera				1514 Division Street BALTIMORE, MARYLAND					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county)		(State)	
		DEC 6 1965		ANATOMY BOARD OF MARYLAND					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
DEC 9 1965		Robert E. Faust		MORTUARY SERVICE - BCHD					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12550		CITY HEALTH DEPT. BALTIMORE		Registered No. 65 12550	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) KATE WELDON			2. DATE AND HOUR OF DEATH Catherine 12-4-65		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 904 Cherry Hill Road			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
D. STREET ADDRESS (If rural, give location) 904 Cherry Hill Road					
5. SEX F	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widow	8. DATE OF BIRTH May 1, 1892	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days 7 2
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAID			10B. KIND OF BUSINESS OR INDUSTRY NO NE		11. BIRTHPLACE (State or foreign country) HARFORD COUNTY MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME William Johnson			14. MOTHER'S MAIDEN NAME Maggie ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 212-26-8350		17. INFORMANT ELSIE HALL
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.11			CAUSE OF DEATH ARTERIO SCLEROTIC HEART DISEASE 1 1/2 YRS.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) CORONARY HEART DISEASE 11 DAYS		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. SENILITY					
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 19 68 to 11-25 19 65 , that (I) was lost saw the deceased alive on 12-4 19 65 and that in (my) was opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jerry C. Luck				23B. DATE SIGNED 12-4-65	
23C. PHYSICIAN'S NAME (Type) Jerry C. Luck				23D. ADDRESS 427 Swale Rd, Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-7-65		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery, Brooklyn Maryland	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1965		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Joseph H. Russ	
25D. ADDRESS		2222 W. North Ave			

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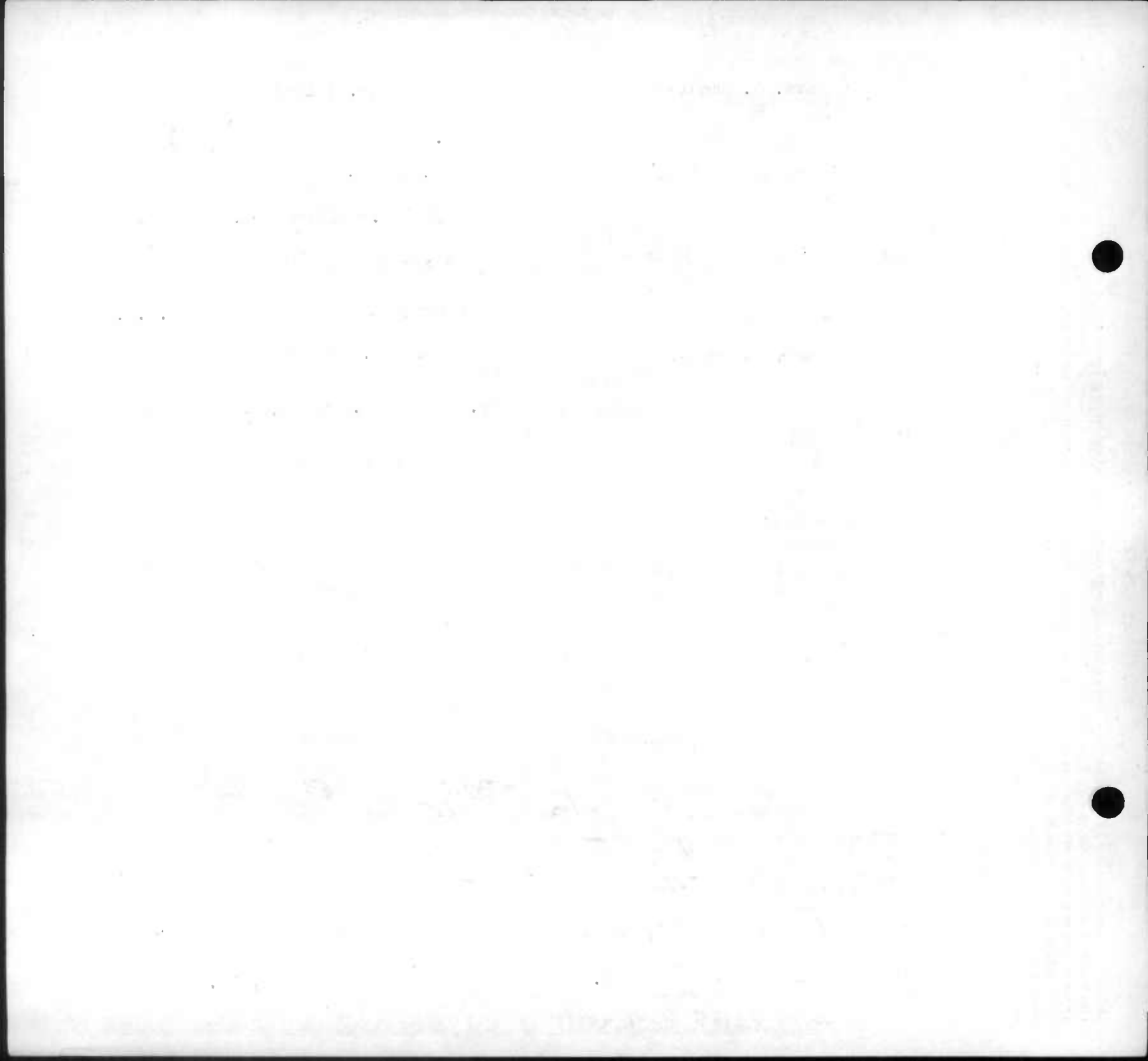
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12551	
BIRTH NO. 65 12551		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH Dec. 7 1965			
1. NAME OF DECEASED (Type or Print) Eva. C. Randles		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1701			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 520 W. Mulberry St. 2121			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH May 11, 1889	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Isaiah Rensburg		14. MOTHER'S MAIDEN NAME Lenora V. Routzahn	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Mr. Charles K. Randles 1620 Waverly Way	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.0 I		CAUSE OF DEATH (A) DUE TO ARTERIOSCLEROTIC Heart Dis.		INTERVAL BETWEEN ONSET AND DEATH YEARS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 3/15 1963 to 12/7 1965 , that (I) (we) last saw the deceased alive on 11/10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Irvin B. Kaplan		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/8/65	
23C. PHYSICIAN'S NAME (Type) Irvin B. Kaplan		M.D. 23D. ADDRESS 129 S. Broadway BALTO 3, Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/10/65		24C. NAME OF CEMETERY or CREMATORY St. Paul	
24D. LOCATION (City, town, or county) (State) Myersville, Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 9 1965		25B. NAME OF REGISTRAR William J. Dickner + Sons' Nuch + Partners	
25C. FUNERAL DIRECTOR ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12552		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 12552	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) HONEYWELL, ELMER MY Mitchell		2. DATE AND HOUR OF DEATH DECEMBER 7, 1965 11:00A.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Q. A. County			
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	
8. DATE OF BIRTH 11-16-1900		9. AGE (In years last birthday) 65		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTORNEY		10B. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FRANCIS LEVI HONEYWELL		14. MOTHER'S MAIDEN NAME VIRGINIA MITCHELL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 214-0177829		17. INFORMANT ST. AGNES HOSPITAL RECORDS	
18. 527.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Malabsorption Syndrome (B) Due to Probable Malabsorption (C) Syndrome (Severe malnutrition) Congestive lungs and liver Emphysema bilateral		INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from AUGUST 29 1965 to DECEMBER 7 1965 , that (I) (we) last saw the deceased alive on DECEMBER 7 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Cemil Goral		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-7-65	
23C. PHYSICIAN'S NAME (Type) CEMIL GORAL		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial 12/10/65		24B. DATE 12/10/65		24C. NAME of CEMETERY or CREMATORY Morland	
24D. LOCATION (City, town, or county) (State) Balt Md		25A. DATE REC'D BY HEALTH DEPT. DEC 9 1965			
25B. NAME OF REGISTRAR R. E. F. J. J. J.		25C. FUNERAL DIRECTOR Wm. J. J. J. J. J.			

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65 12553 BIRTH NO. 65-24640 M.E. CASE NO.				BALTIMORE CITY HEALTH DEPARTMENT MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12553			
1. NAME OF DECEASED (Type or Print) HENRY WYMAN				2. DATE AND HOUR PRONOUNCED DEAD December 7, 1965 2:20 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pikesville, Maryland Pikesville D. STREET ADDRESS (If rural, give location) 7802 Ridge Terr. 21208			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Sept. 27, 1965	9. AGE (In years last birthday) 2	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. 11		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never worked			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME M. Richard Wyman				
14. MOTHER'S MAIDEN NAME Marjorie Weinstock			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. None			17. INFORMANT Mr. M. Richard Wyman				
18. ADDRESS as above			19. CAUSE OF DEATH Interstitial pneumonitis				
20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) INTERSTITIAL PNEUMONITIS			21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. None				
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None			23. INTERVAL BETWEEN ONSET AND DEATH 5-25 X 1				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED yes		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. yes		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) home			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 12/9/65		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? Autopsy			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Rudiger Breiteneker, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12-8-65	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 12/9/65		23C. NAME OF CEMETERY or CREMATORY Druid Ridge		23D. LOCATION (City, town, or county) (State) Pikesville Md.	
24A. DATE REC'D BY HEALTH DEPT. DEC 9 1965		24B. NAME OF REGISTRAR William J. Pickens		24C. FUNERAL DIRECTOR William J. Pickens Sons North + Pa. ans			

VALLEY POLICE

REPORT

[Handwritten signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12554		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12554	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Daisy Mabel Costin			2. DATE AND HOUR OF DEATH Dec 6, 1965 11:15 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 21-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1155 Cleveland St.		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 1/10/24	9. AGE (In years last birthday) 41	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Benny			14. MOTHER'S MAIDEN NAME Sheppard		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. NO		17. INFORMANT Mrs. Audrey Mills ADDRESS 260 South Monastery Ave. Baltimore, Md. 29	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 13 hours			(A) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Brain Disease			(C) Generalized Arteriosclerosis		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 5 1965 to Dec 6 1965 , that (I) (we) last saw the deceased alive on Dec 6 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harold C. Standford M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 12/6/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9/1965		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery	
				24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1965		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Wm. A. Johnson & Son North & A. Ave.	



42-28-14

JJ

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

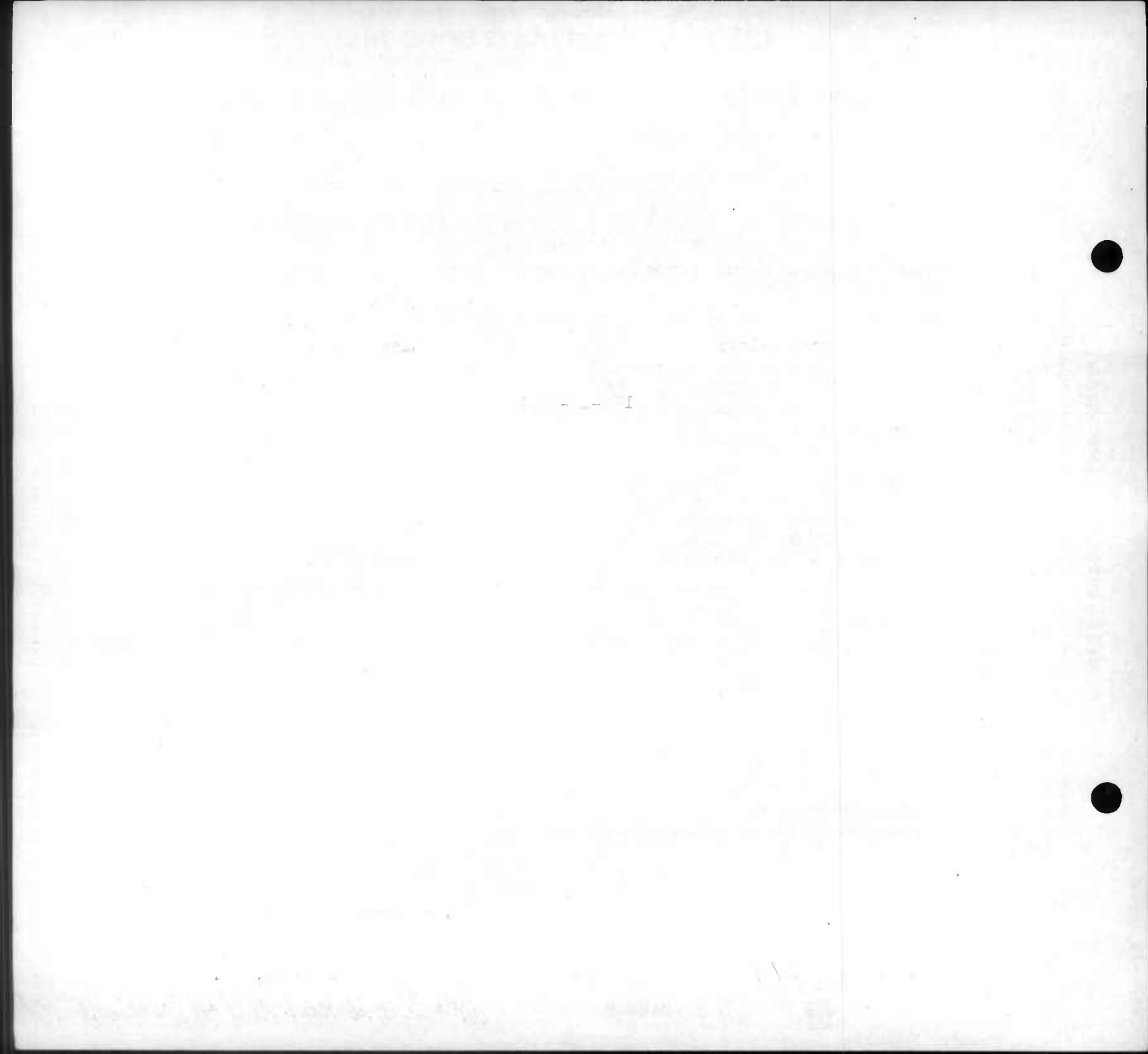
F-435 BIRTH NO. 65 12555		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 12555	
M.E. CASE NO. 5-200			2. DATE AND HOUR OF DEATH 12-7-65 - 2PM		
1. NAME OF DECEASED (Type or Print) Case - Amy Felton			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-14		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224			5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4940 Eastern Ave. 21224 21210		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 4-21-94	9. AGE (In years last birthday) 71	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Investigator
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Balto. Transit Co	11. BIRTHPLACE (State or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Albert Felton			14. MOTHER'S MAIDEN NAME Louise Blanding		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS RECORDS: BGH-4940 EASTERN AVENUE #21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 260X I ASCVD		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) diabetes		INTERVAL BETWEEN ONSET AND DEATH years years	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. cerebral artery disease			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-4 1965 to 12/7 1965, that (I) (we) last saw the deceased alive on 12/7 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harry Dean Albert			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/7/65
23C. PHYSICIAN'S NAME (Type) DR. HARRY DEAN ALBERT			23D. ADDRESS M.D. 4940 EASTERN AVENUE		
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 12/10/65		24C. NAME OF CEMETERY or CREMATORY Greenmount	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. STATE (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1965		25B. NAME OF REGISTRAR Robert E. Felton		25C. FUNERAL DIRECTOR William J. Zickner + Sons North + Penna Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12556	
BIRTH NO. 65 12556		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Alexander C. Weiser</i>			2. DATE AND HOUR OF DEATH <i>12.8.65 9:48 P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md</i> B. COUNTY <i>4-01</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland General Hospital</i>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		
(If not in hospital or institution, give street address or location)			D. STREET ADDRESS (If rural, give location) <i>419 N. Charles St.</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>8.29.95</i>	9. AGE (In years last birthday) <i>70</i>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>curl engineer</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>J.E. Greiner Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Yugoslavia</i>
12. CITIZEN OF WHAT COUNTRY? <i>?</i>			13. FATHER'S NAME <i>Aurel Weiser</i>		
14. MOTHER'S MAIDEN NAME <i>Elsa</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>?</i>		
16. SOCIAL SECURITY NO. <i>159-18-5972</i>			17. INFORMANT <i>Acc Rm Chart</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Acute MI</i>			INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			20. CAUSE OF DEATH <i>ASCVD</i>		
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			22. MEDICAL CERTIFICATION		
23A. DATE OF OPERATION <i>0</i>		23B. CONDITION FOR WHICH OPERATION WAS PERFORMED		24A. AUTOPSY? (Yes or No) <i>NO</i>	
25A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		26A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		27A. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
28A. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		29A. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		30A. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>12.8.1965</i> to <i>12.8.1965</i> , that (1) (we) last saw the deceased alive on <i>12.8.1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>				23B. DATE SIGNED <i>12.8.65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Md. General Hospital</i>				23D. ADDRESS <i>Md. General Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>		24B. DATE <i>12/9/1965</i>		24C. NAME OF CEMETERY or CREMATORY <i>Greenmount</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 9 1965</i>			
25B. NAME OF REGISTRAR <i>[Signature]</i>		25C. FUNERAL DIRECTOR <i>[Signature]</i>			
25D. ADDRESS <i>[Signature]</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

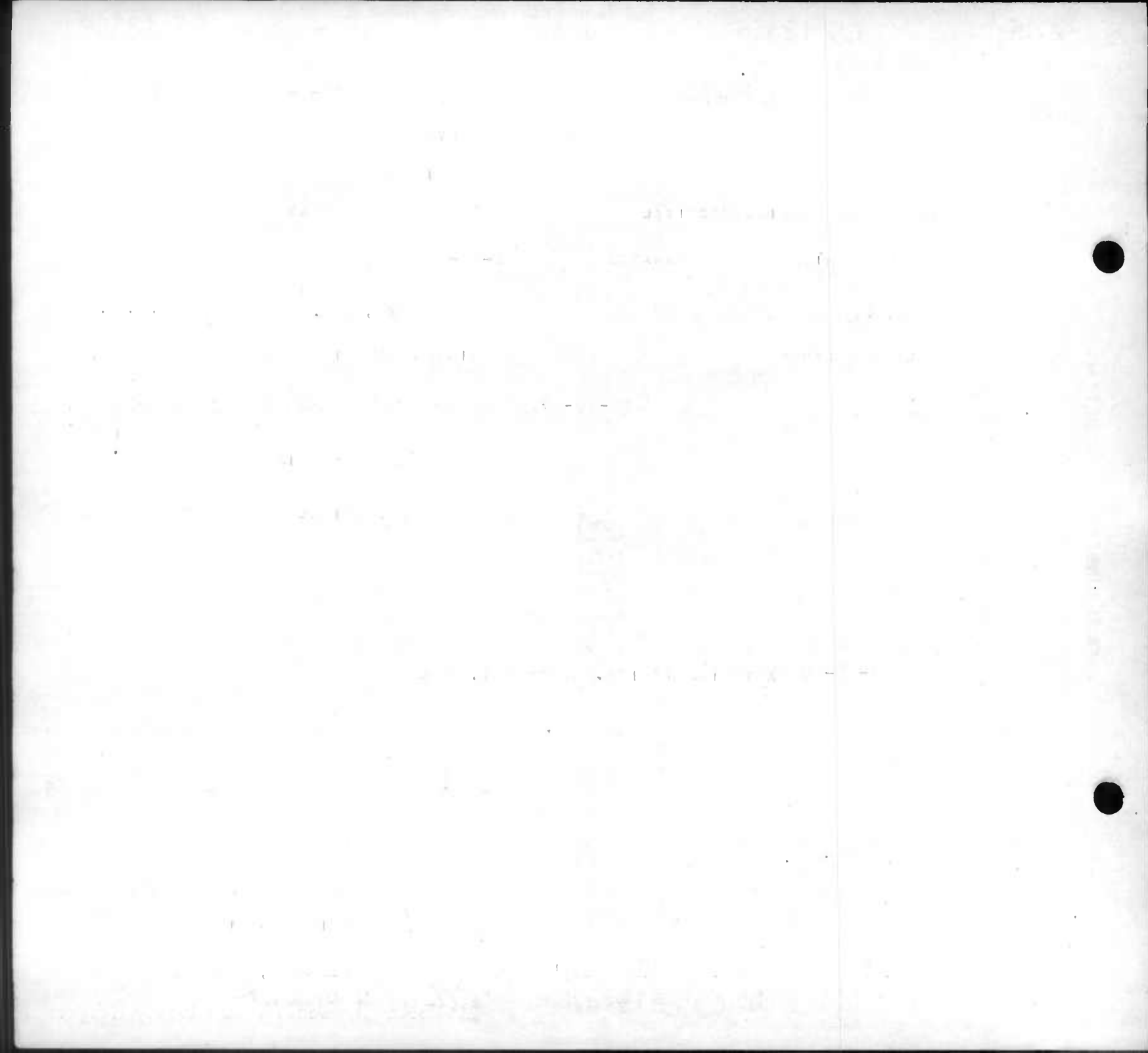
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>65 12557</u>	
BIRTH NO. <u>65 12557</u>							
M.E. CASE NO. <u>65 12557</u>							
1. NAME OF DECEASED (Type or Print) <u>DOLLIE REDMOND</u>				2. DATE AND HOUR OF DEATH <u>12/6/65</u> <u>11:40</u> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>LUTHERAN HOSPITAL OF MARYLAND</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>MD.</u>		B. COUNTY <u>15-02</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
				D. STREET ADDRESS (If rural, give location) <u>1839 W. NORTH AVE.</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED <u>MARRIED</u>	8. DATE OF BIRTH <u>7-19-1965</u>	9. AGE (In years last birthday) <u>60</u>	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>King & Queen Co., VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Crist Jones</u>			14. MOTHER'S MAIDEN NAME <u>Edna Green</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mr. J. Redmond - 1839 W. North Ave.</u>		
18. <u>578X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>SHOCK</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>PROB. G-I Bleeding massive 1 week</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Probable Myocardial Infarction</u>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<u>0</u>				<u>Yes</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
<input type="checkbox"/>							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Net While <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12/2</u> 19 <u>65</u> to <u>12/6</u> 19 <u>65</u> that (I) (we) last saw the deceased alive on <u>12/6/65</u> 19 <u>11:40AM</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>F. S. Reroma</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12/6/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>F. S. Reroma</u>				23D. ADDRESS <u>LUTHERAN HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-12-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Union Prospect Church Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>King & Queen Co. VA.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 9 1965</u>		25B. NAME OF REGISTRAR <u>R. E. Taylor</u>		25C. FUNERAL DIRECTOR <u>M. G. Dyer</u>		ADDRESS <u>1701 Laurens ST.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12558		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12558	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) W. ROBERT Salfner		2. DATE AND HOUR OF DEATH 12-7-65 7:45AM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 2926 HARFORD ROAD			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SEPARATED	8. DATE OF BIRTH 2-21-99	9. AGE (In years last birthday) 66	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trucking
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trucking		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME WALTER Salfner		14. MOTHER'S MAIDEN NAME WINONA WALLET		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-16-1759		17. INFORMANT ADDRESS Leonard Salfner 2031 Woodlawn Drive #7	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) RENAL TUBALER NECROSIS DUE TO (B) XSM GASTRO INTESTINAL HEMORRHAGE DUE TO (C) ASCVD		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION X2 11-17-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ARTERIAL INSUFF. LOWER EXT. YES		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-15-1965 to 12-7-1965, that (I) (we) last saw the deceased alive on 12-7-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/7/65	
23C. PHYSICIAN'S NAME (Type) J. S. Danner		23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/10/65		24C. NAME of CEMETERY or CREMATORY Saint Mary's Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1965		25B. NAME OF REGISTRAR Robert E. Salfner		25C. FUNERAL DIRECTOR Ellisworth Armacost	
				ADDRESS 4600 Liberty Heights	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12559	
BIRTH NO. 20 65 12559		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) GOLDSMITH, MARY FRANCES		2. DATE AND HOUR OF DEATH 12-8-65 2:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 28-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 903 NOTTINGHAM RD.	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 10-25-95
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) 70	11. BIRTHPLACE (State or foreign country) MARYLAND
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ABLERT WALLIS		14. MOTHER'S MAIDEN NAME MARGARET SAMUEL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT CATON AVES. 21229 ST AGNES HOSPITAL RECORDS, WILKINS AND		ADDRESS	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Vascular Accident. INTERVAL BETWEEN ONSET AND DEATH 11-28-1965 12-8-1965		(A) DUE TO (B) DUE TO (C) DUE TO	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11-28-65 to 12-8-65 that (I) (we) last saw the deceased alive on 12-8-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Carl Matthey		23B. DATE SIGNED 12-8-65	
23C. PHYSICIAN'S NAME (Type) CARL MATTHEY		23D. ADDRESS ST AGNES HOSPITAL, BALTIMORE 29, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/11/65	
24C. NAME OF CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Bethesda, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1965		25B. NAME OF REGISTRAR Robert E. Fadden	
25C. FUNERAL DIRECTOR W. H. P. & W. H. O. E. Edmondson		ADDRESS 1101 E. Edmondson Ave	

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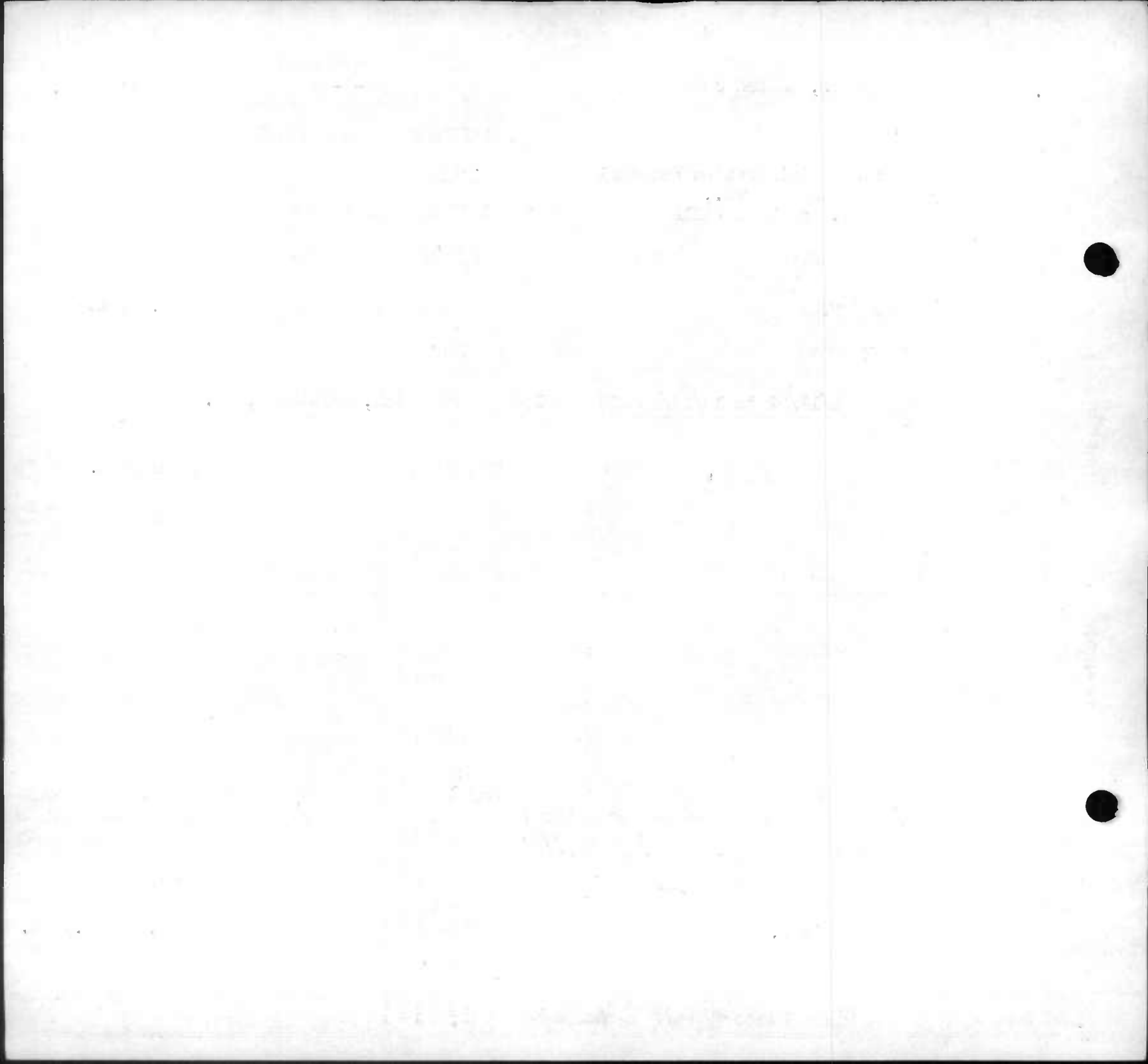
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

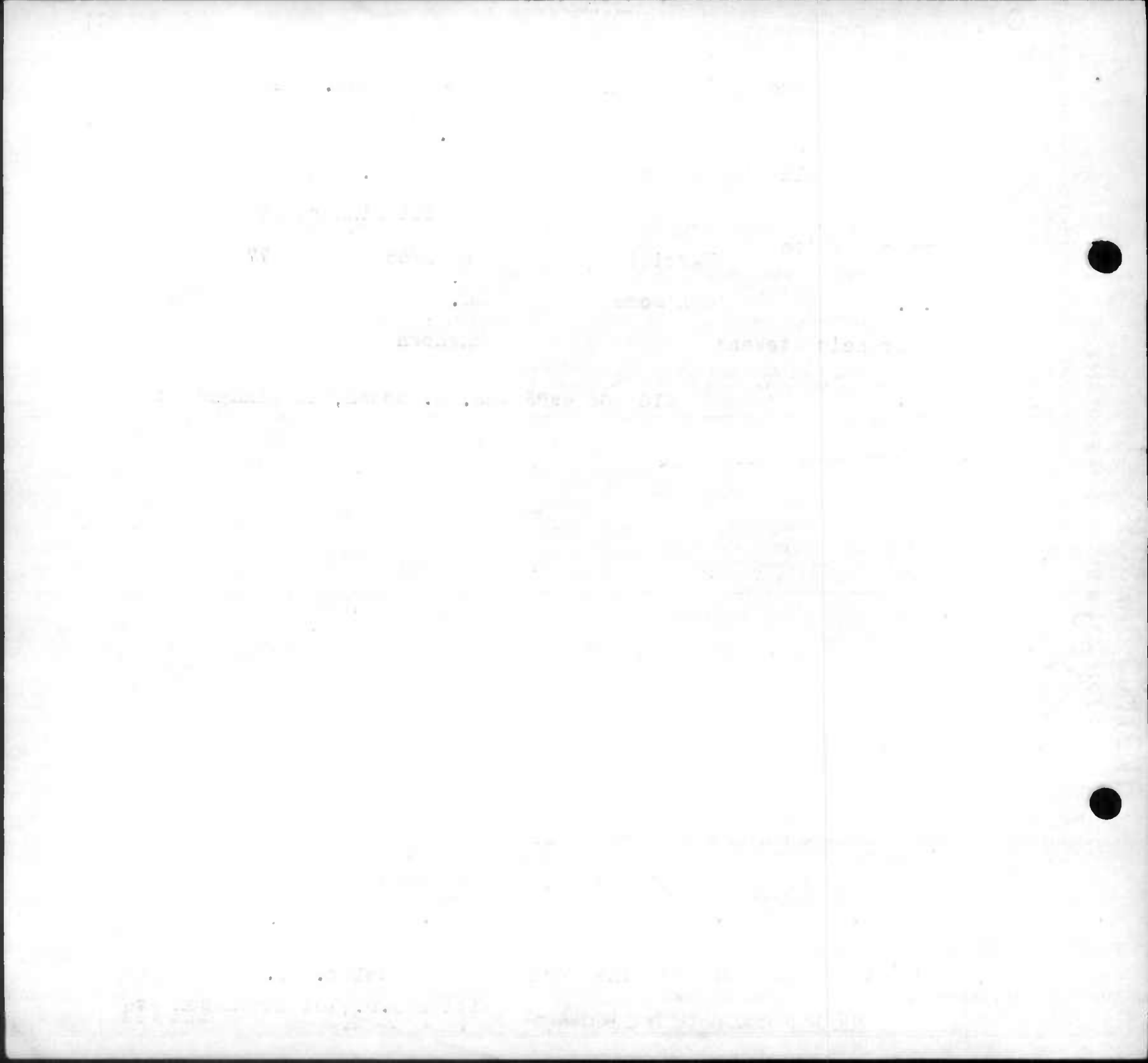
BALTIMORE CITY HEALTH DEPARTMENT				BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO. (4) 65 12560				CERTIFICATE OF DEATH	
M.E. CASE NO.				Registered No. 65 12560	
1. NAME OF DECEASED (Type or Print) QUOSS, WALTER JOHN			2. DATE AND HOUR OF DEATH 12-7-65 7:10 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Blvd., Baltimore, Maryland 21218			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1110 DANIELS AVENUE		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2/1/12	9. AGE (In years last birthday) 53	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MEAT CUTTER			11. BIRTHPLACE (State or foreign country) BONANZA, ARKANSAS		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME GODFREY QUOSS			14. MOTHER'S MAIDEN NAME JOHANNA ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 4/15/42 to 10/18/45			16. SOCIAL SECURITY NO. 217 07 9130		
17. INFORMANT VA Hospital, Baltimore, Md. 21218			ADDRESS		
18. I 527.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) PULMONARY EMPHYSEMA DUE TO CORPULMONALE (B) CORPULMONALE DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 4 years 4 years
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) NO			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from May 1 1965 to December 7 1965 , that (I) (we) last saw the deceased alive on December 7 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frederic B. Asken			23B. DATE SIGNED 12/7/65		
23C. PHYSICIAN'S NAME (Type) Frederic B. Asken			23D. ADDRESS Veterans Administration Hospital, Balto., Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) 12/10/65 Burial		24B. DATE DEC 9 1965		24C. NAME OF CEMETERY or CREMATORY Balto. Nat	
24D. LOCATION (City, town, or county) (State) Balto 29. Md		25A. DATE REC'D BY HEALTH DEPT. DEC 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR W. H. F. A. 10. 41016		25D. ADDRESS Edmondson			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 12561		CERTIFICATE OF DEATH		Registered No. 65 12561	
1. NAME OF DECEASED (Type or Print) Emma Adelia Bowen				2. DATE AND HOUR OF DEATH Dec. 6/65					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 611 Linnard St				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 16-08					
5. SEX Female				6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH May 9/88	
9. AGE (In years last birthday) 77				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francis Stevens				14. MOTHER'S MAIDEN NAME Unknown					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 216 05 4985		17. INFORMANT ADDRESS Geo. H. Bowen, 611 Linnard St			
18. 430.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) acute coronary thrombosis DUE TO (B) hypertensive cardiovascular disease DUE TO (C) arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 1 day	
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2-10-58 19 12-7 19 65 , that (I) (we) last saw the deceased alive on 12-7 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Luther E. Little				M.D. <input checked="" type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-7-65			
23C. PHYSICIAN'S NAME (Type) Luther E. Little				23D. ADDRESS M.D. 10 W. Madison St.					
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 12/8/65		24C. NAME of CEMETERY or CREMATORY Lorraine Park		24D. LOCATION (City, town, or county) (State) Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1965		25B. NAME OF REGISTRAR R. E. Feltz		25C. FUNERAL DIRECTOR Witzke R.D.		ADDRESS 1101 Edmondson Ave			



65 12562

BALTIMORE CITY HEALTH DEPARTMENT

65 12562

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE W. SCOTT

2. DATE AND HOUR PRONOUNCED DEAD

December 8, 1965 6:10 P

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1516 Ashland Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

March 3, 1923

9. AGE (In years
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George Scott

14. MOTHER'S MAIDEN NAME

Lurenia

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes World War 2

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Lurenia Scott 1516 Ashland Ave

18. 587.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Acute and Chronic Pancreatitis.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/9/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

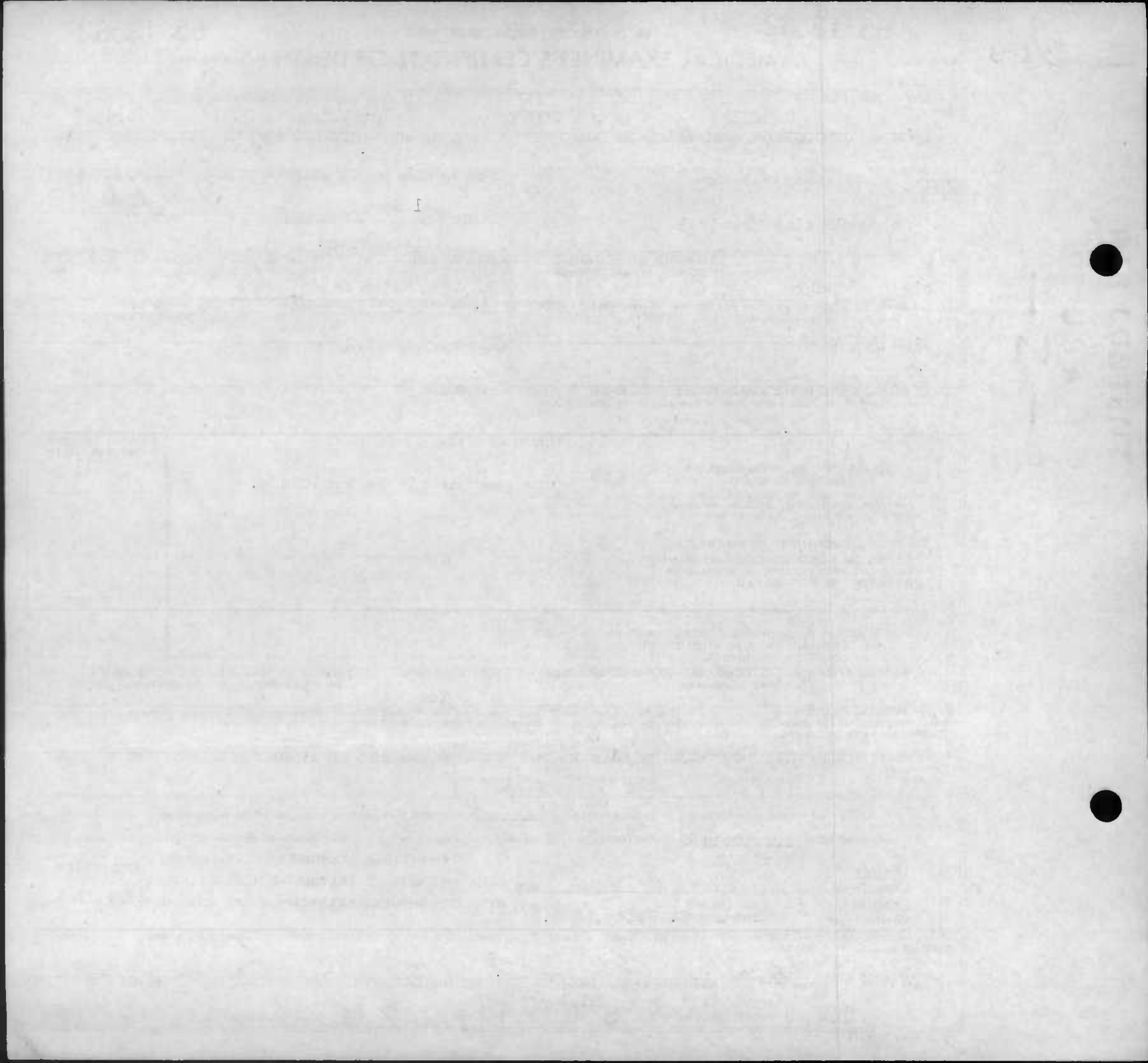
24C. FUNERAL DIRECTOR

ADDRESS

DEC 9 1965

Robert E. Petty, M.D.

Frederick E. Peterson 11297 Carroll St



1
B-340

65 12563

BALTIMORE CITY HEALTH DEPARTMENT

65 12563

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

WILLIAM BATTLE

2. DATE AND HOUR PRONOUNCED DEAD

12-6-65

7:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

MARYLAND GENERAL HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1756 Park Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Feb 11, 1898

9. AGE (In years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Janitor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Tarboro N. Carolina

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Kwaleh Battle

14. MOTHER'S MAIDEN NAME

Mary?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mary L Battle 1919 Kelly Ave

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) Ruptured myocardial infarction
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Arteriosclerotic cardiovascular disease
DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

CHARLES S. PETTY

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-6-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Dec. 10/65

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem

23D. LOCATION

Westport Md.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 9 1965

24B. NAME OF REGISTRAR

Robert E. Satterly

24C. FUNERAL DIRECTOR

Muller & Erickson 11297 Carver St

ADDRESS

WALLACE P. ROSE

H 626

65 12564

BALTIMORE CITY HEALTH DEPARTMENT

65 12564

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ARTHUR HARGROVE

2. DATE AND HOUR PRONOUNCED DEAD

12-5-65

10:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

PROVIDENT HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1525 Riggs Avenue 21217

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 10 1913

9. AGE (In years last birthday)

52

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laboren

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTH PLACE (State or foreign country)

Durham N. Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Eddie Hargrove

14. MOTHER'S MAIDEN NAME

Alie Austin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Orville Hargrove 1525 Riggs Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

CHAS. S. PETTY, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-6-65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

12/9/65

23C. NAME of CEMETERY or CREMATORY

Carver Memorial

23D. LOCATION

(City, town, or county)

(State)

Laurel Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 9 1965

24B. NAME OF REGISTRAR

Robert E. Taylor M.D.

24C. FUNERAL DIRECTOR

Milton E. Elickson 129 N. Central St.

ADDRESS

March 1911

Little Hagerman

Little Hagerman

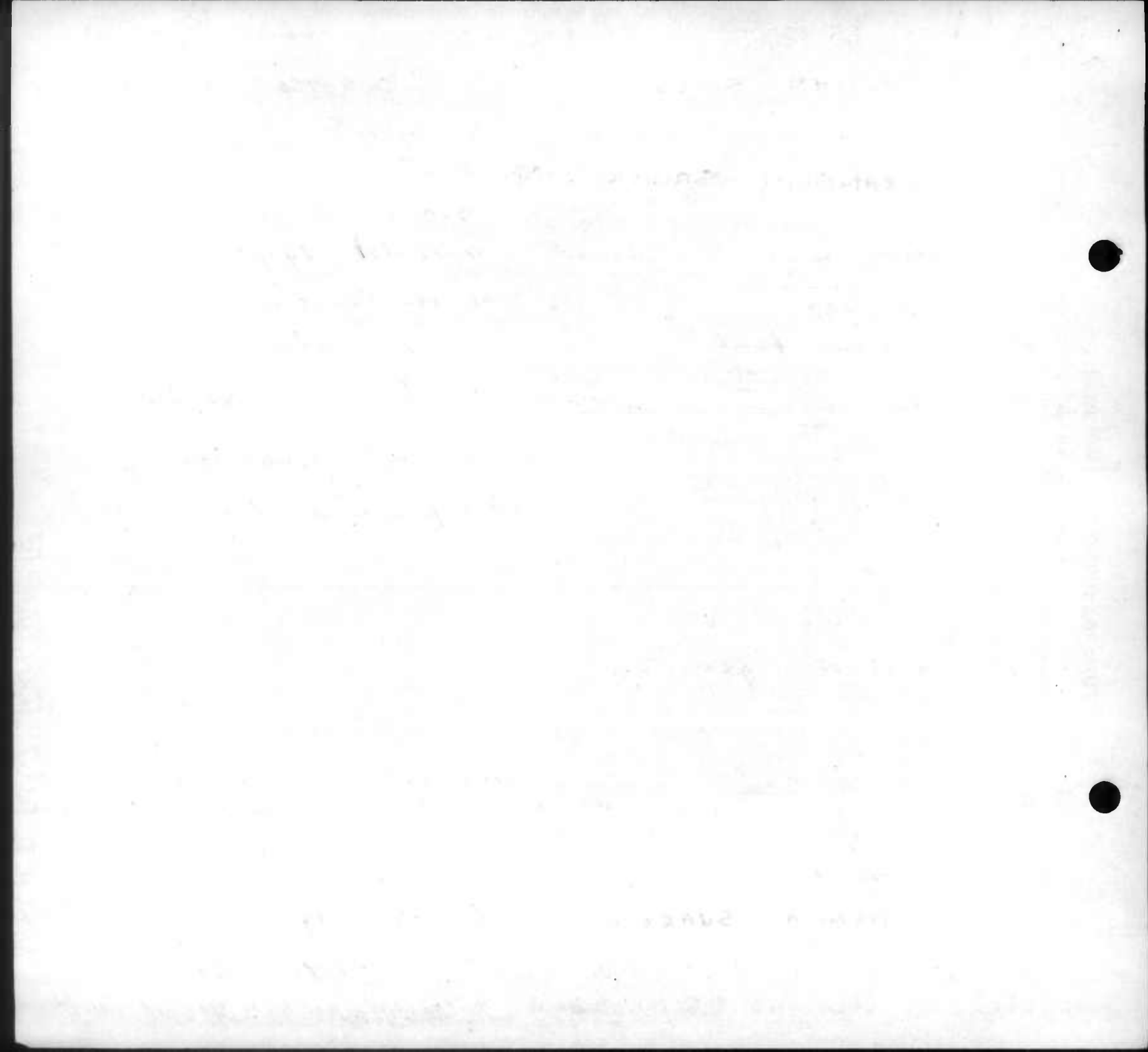
March 1911

Little Hagerman

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

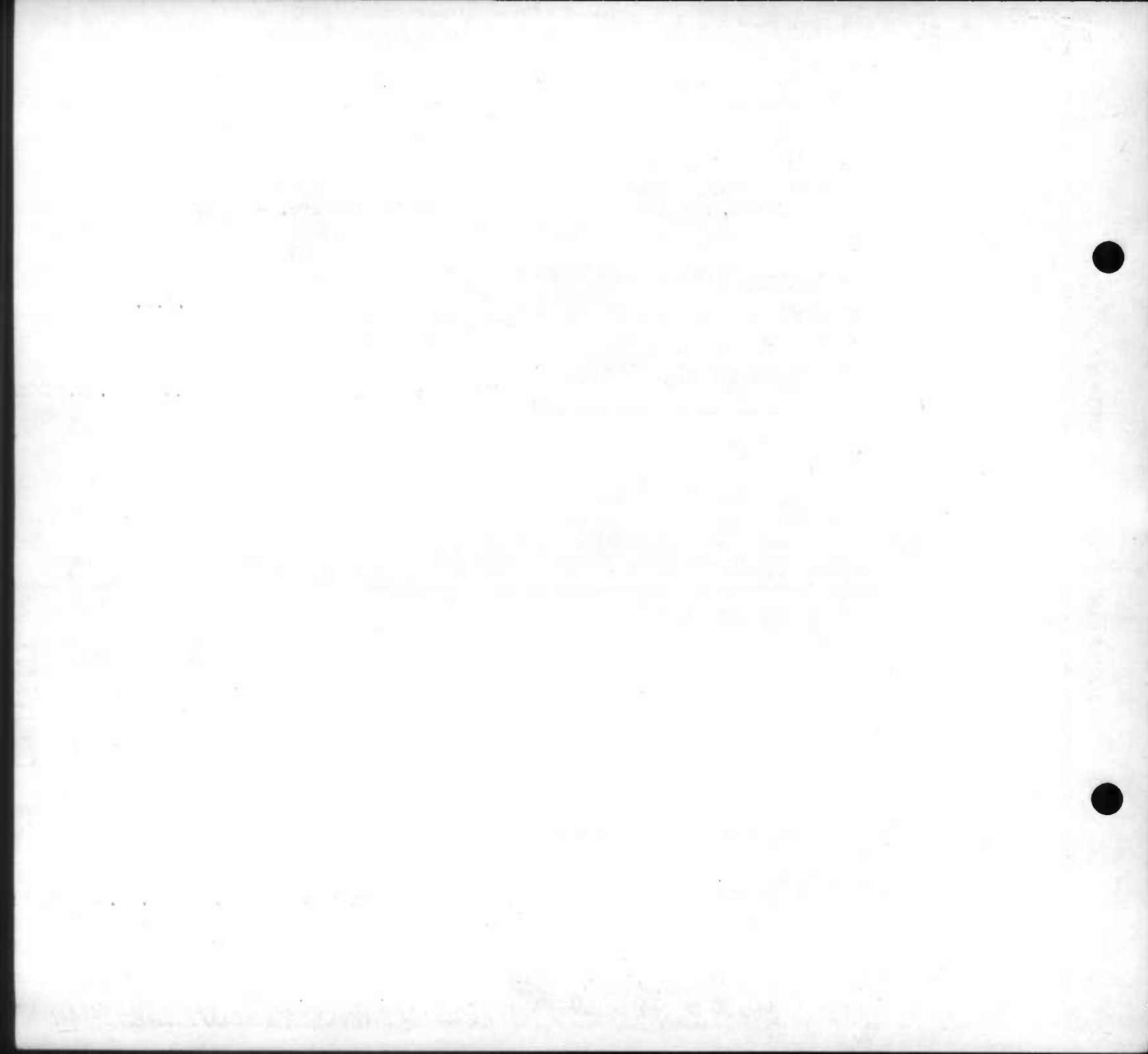
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 12565	
BIRTH NO. 65 12565		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOHN SAULS		2. DATE AND HOUR OF DEATH DECEMBER 8, 1965 12:00	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSP.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1901			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 33		D. STREET ADDRESS (If rural, give location) 310 N. Gilmore St.	
5. SEX male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed		8. DATE OF BIRTH 4-15-1891	9. AGE (In years last birthday) 74 yrs.	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Olson Sauls				14. MOTHER'S MAIDEN NAME Esther Thompson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 218-075730		17. INFORMANT chart		ADDRESS 320XMS	
18. 584X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Pulmonary Embolism DUE TO (B) Postoperative condition DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 11-29-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED gallstones		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11-5-65 19 to 12-8 19 65 , that (I) (we) last saw the deceased alive on Dec. 8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Mita Rung				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-8-65	
23C. PHYSICIAN'S NAME (Type) NENITA SUAREZ				23D. ADDRESS M.D. Franklin Square Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 13, 1965		24C. NAME of CEMETERY or CREMATORY Baltimore National Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1965		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 319 N. Schroeder St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

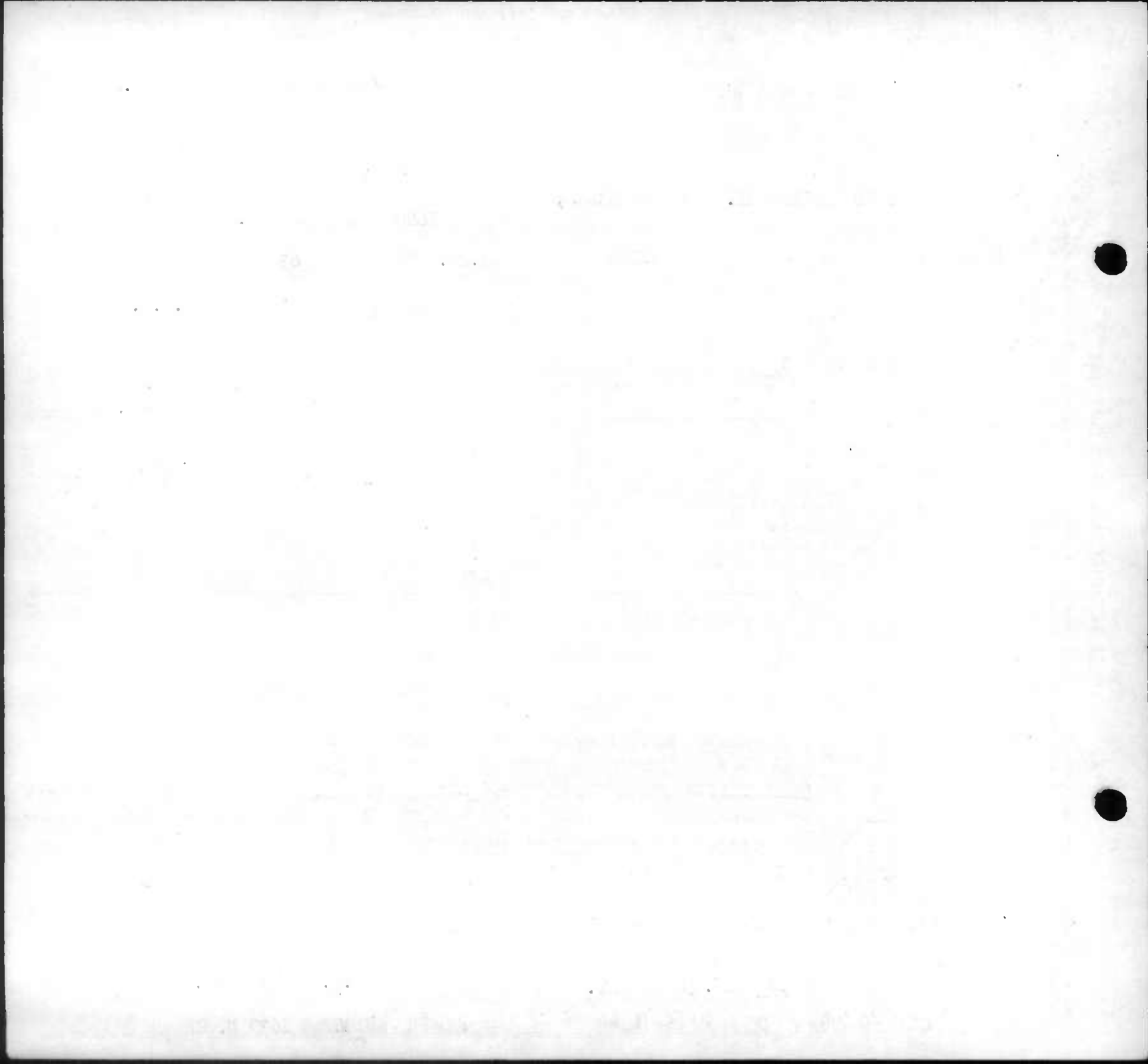
36-57-93 NIW		65 12566		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12566	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)			
LEONORA TURNAGE				2. DATE AND HOUR OF DEATH Dec. 7, 1965 3 ⁰⁰ 4 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE MARYLAND B. COUNTY 14-03			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 2129 Druid Hill Ave. - 21217			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 3/12/16	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N C		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bob Taylor				14. MOTHER'S MAIDEN NAME Amelia Lanes			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 239-28-2135		17. INFORMANT RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) I 157X I CAUSE OF DEATH (A) METASTATIC ADENOCARCINOMA OF PANCREAS (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH > 4 mos.							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Nov. 23 19 65 to Dec. 7 19 65, that (I) (we) last saw the deceased alive on Dec. 7 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Barry Wayne Ular				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Dec. 7, 1965	
23C. PHYSICIAN'S NAME (Type) BARRY WAYNE ULAR				23D. ADDRESS 4940 Eastern Avenue, Balto. Md. 21224 Baltimore City Hospitals			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 10, 1965		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1965		25B. NAME OF REGISTRAR C. E. E. Taylor		25C. FUNERAL DIRECTOR Williams Funeral Home 319 N. Schrock St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 12567	
BIRTH NO. 65 12567				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) MARY JONES WHITE				2. DATE AND HOUR OF DEATH 12/6/65 6:20 P.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) I640 MILLER ST. RESIDENCE,				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MARYLAND B. COUNTY 7-05			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) I640 MILLER ST.			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 10.28.1902		9. AGE (In years last birthday) 63	11. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME HENRY MOSLEY				14. MOTHER'S MAIDEN NAME SUSIE GORDON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT 1		
			ADDRESS GOLDEN NANCE 3326 BURLEITH AVE.				
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis Myocardial Infarction Hypercholesterolemia				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Unrecorded 6:20 PM	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from November 19 63 to 12/6 19 65 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Robert A. Laforest						23B. DATE SIGNED 12/8/65	
23C. PHYSICIAN'S NAME (Type) DR. ROBERT L. LAFOREST				23D. ADDRESS 872 N. BOND ST 21205 MD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12 * 11.65		24C. NAME of CEMETERY or CREMATORY MT. CALVARY		24D. LOCATION (City, town, or county) (State) A.A. COUNTY MD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1965		25B. NAME OF REGISTRAR Robert E. Laforest		25C. FUNERAL DIRECTOR JOSEPH F. KNIGHT		ADDRESS I639 N. BROADWAY	



BIRTH NO.

65 12568

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65-12568

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ELINORA LEE

2. DATE AND HOUR PRONOUNCED DEAD

12-6-65

1:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

FRANKLIN SQUARE HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1100 W. Lexington Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Dec. 25, 1925

9. AGE (in years
last birthday)

39

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Benjamin Oden

14. MOTHER'S MAIDEN NAME

Rachel Benson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Charles LEE - 1100 W. Lexington St

18. 648.3

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Intra-abdominal hemorrhage
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Rupture of gravid uterus
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-6-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-9-65

23C. NAME OF CEMETERY or CREMATORY

Mt Calvary

23D. LOCATION

(City, town, or county)

(State)

Brooklyn AA Co. Md

24A. DATE REC'D BY HEALTH DEPT.

DEC 10 1965

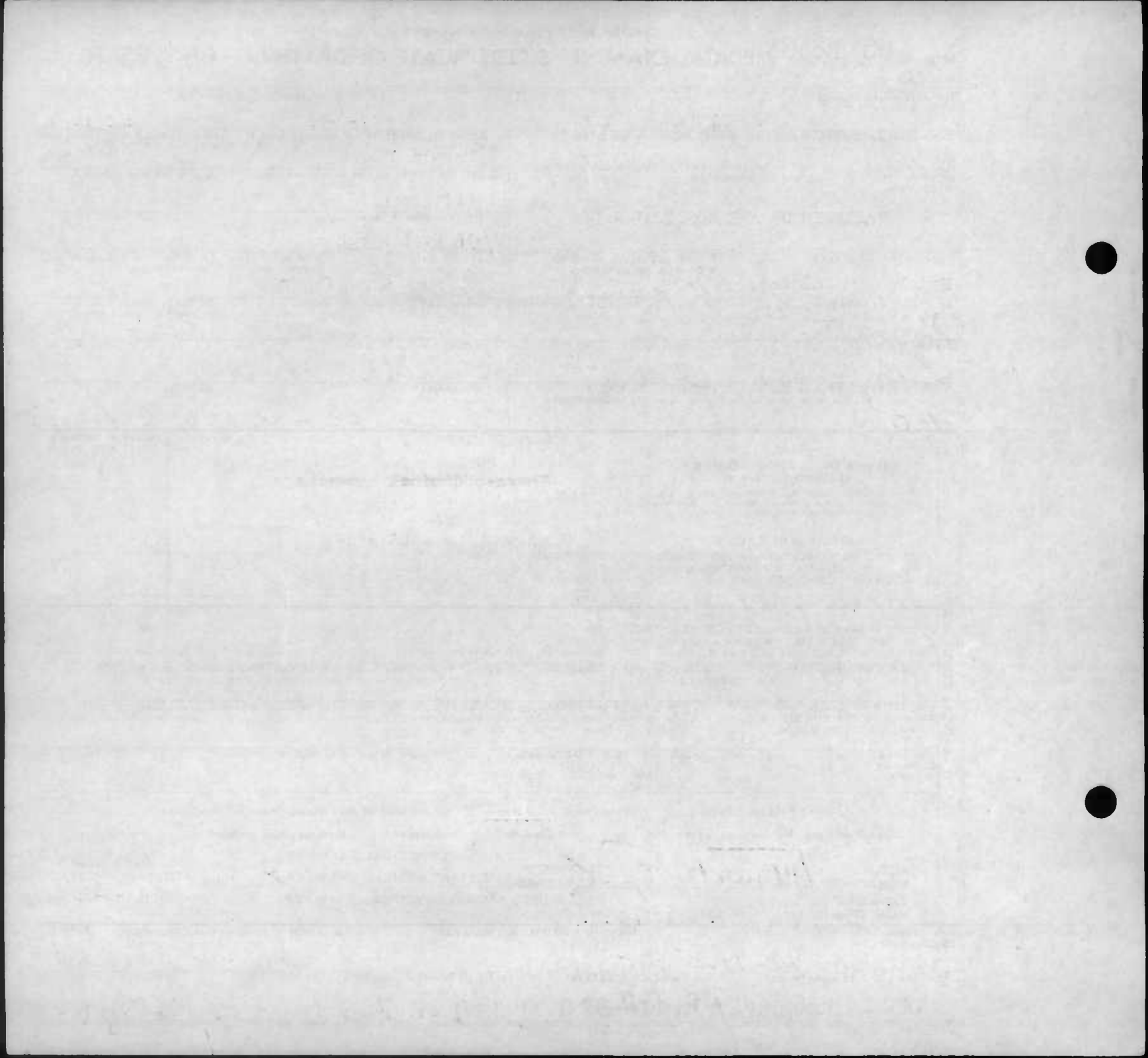
24B. NAME OF REGISTRAR

Robert E. Ferguson

24C. FUNERAL DIRECTOR

Werner U. Spitz Balto Md

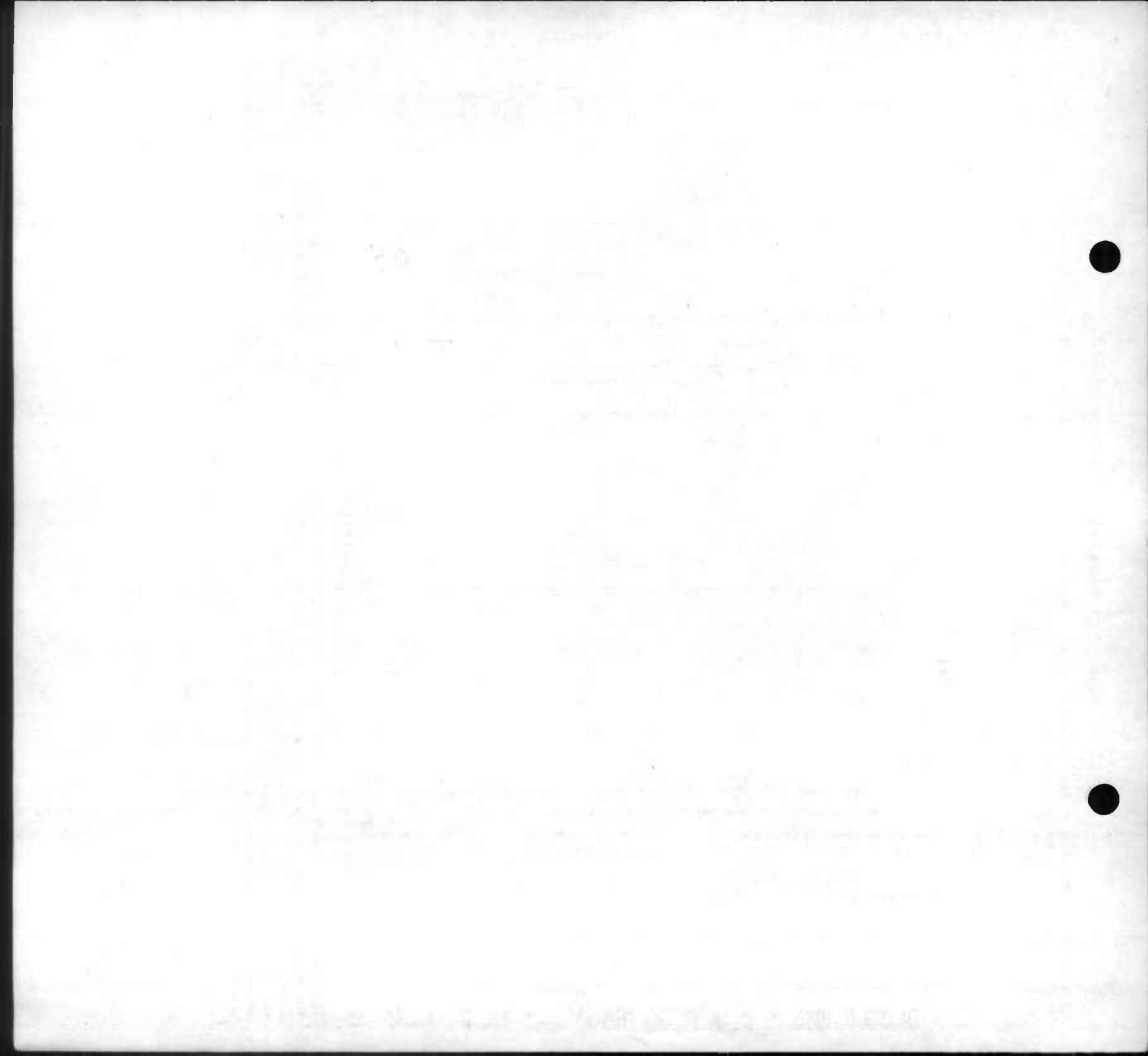
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

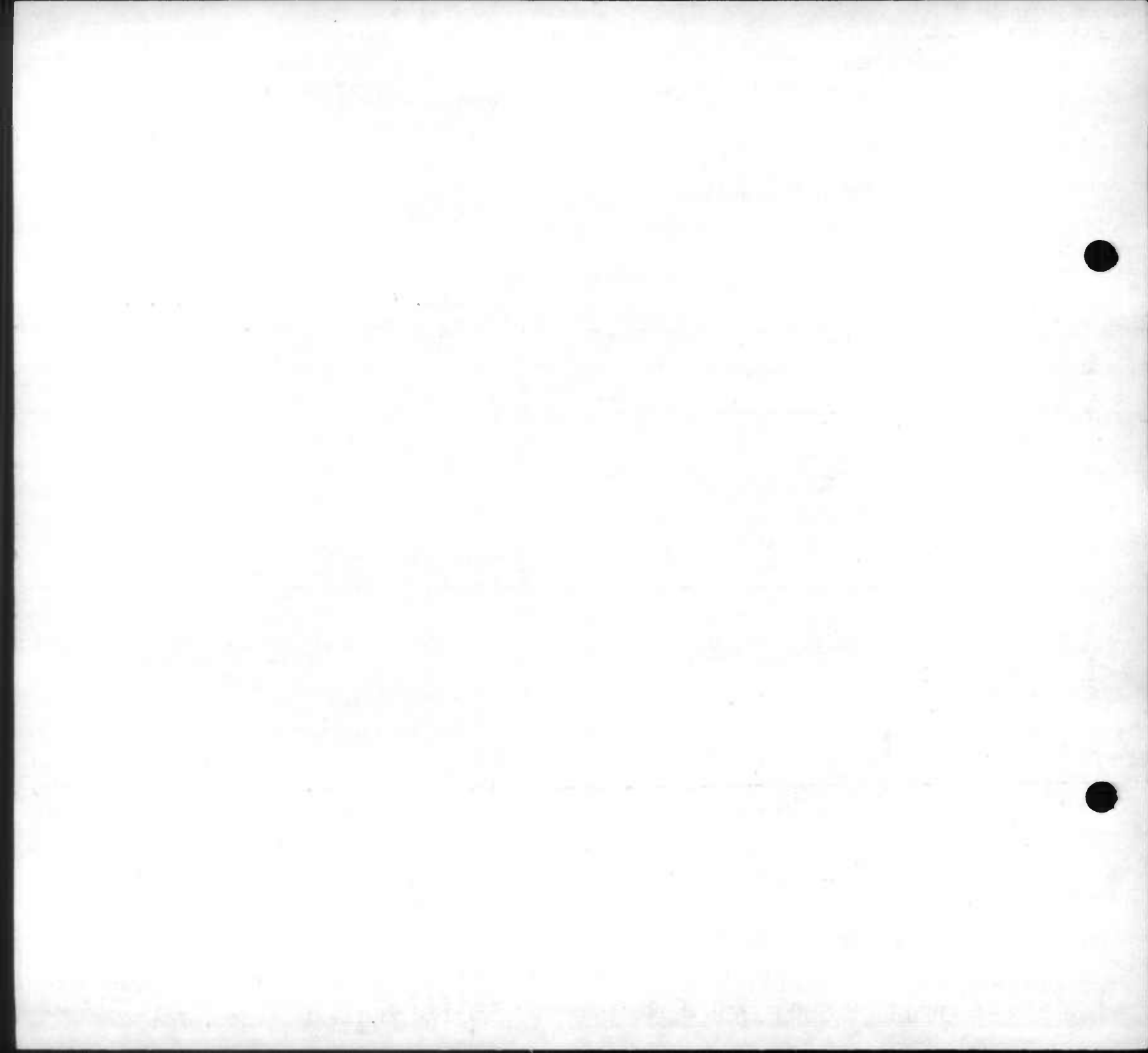
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 12569	
BIRTH NO. 65 12569		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Sarah Gayles - Yales		2. DATE AND HOUR OF DEATH 12/7/65 1:35 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 19-02			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
D. STREET ADDRESS (If rural, give location) 1730 W. Fayette St. #23							
5. SEX F	6. RACE N	7. MARRIED; NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 4/9/04	9. AGE (In years last birthday) 61	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Yales				14. MOTHER'S MAIDEN NAME Catherine Woodlawn			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Theresa McLaughlin 1255 Calverton Rd.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia, R.L., R.M., L.L. lobes.				INTERVAL BETWEEN ONSET AND DEATH 3 days			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION Tracheostomy 12/6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Pneumonia		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 12/6 1965 to 12/7 1965, that (I) lost saw the deceased alive on 12/6 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.							
23A. SIGNATURE Bernard du Buy				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/7/65	
23C. PHYSICIAN'S NAME (Type) Bernard du Buy				23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-11-65		24C. NAME OF CEMETERY or CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1965		25B. NAME OF REGISTRAR John E. Jones		25C. FUNERAL DIRECTOR Bernard du Buy		ADDRESS Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

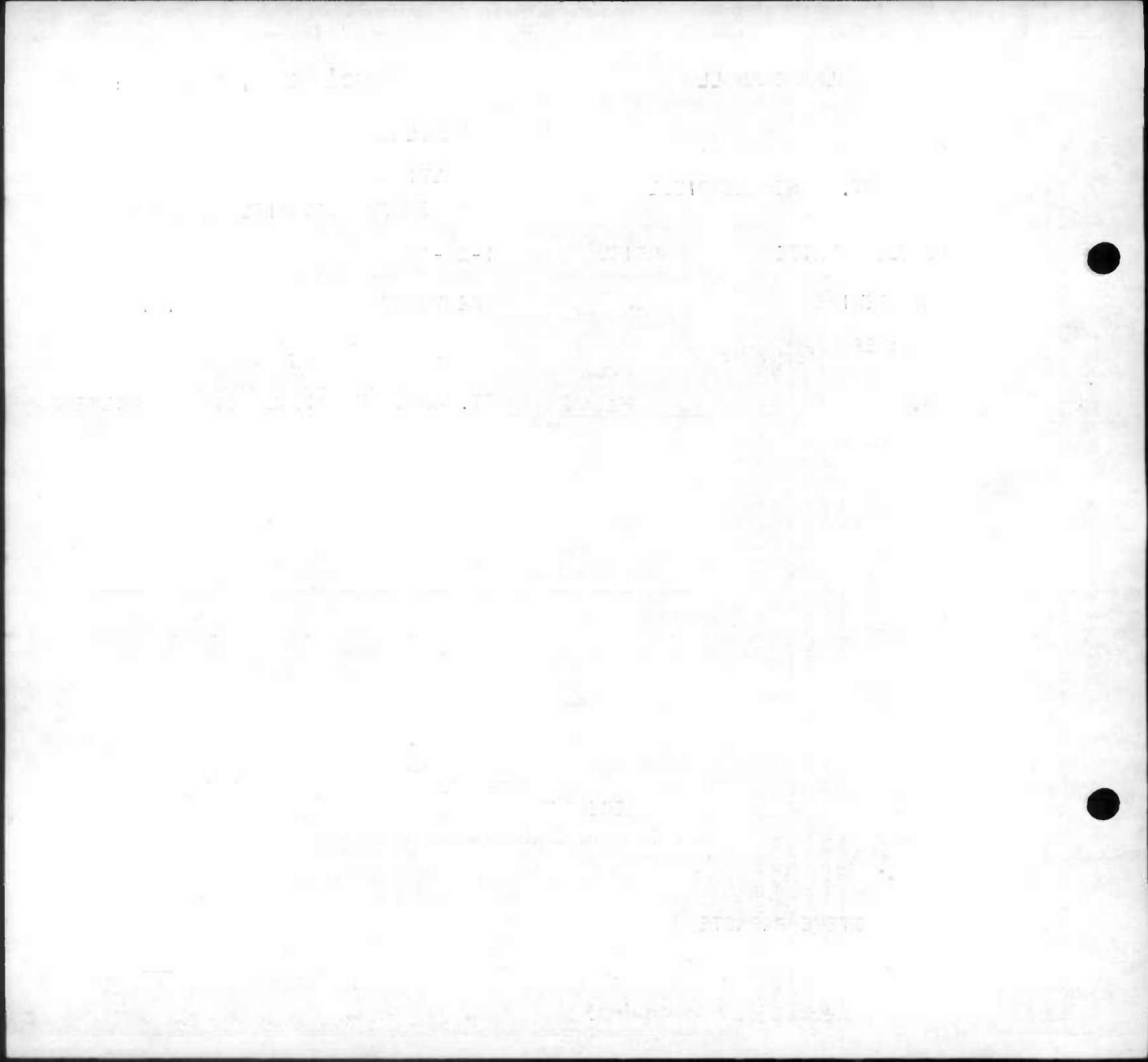
BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
M.E. CASE NO. 65 12570				CERTIFICATE OF DEATH		65 12570	
1. NAME OF DECEASED (Type or Print) Leona Sadie Palees				2. DATE AND HOUR OF DEATH December 7, 1965 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-10			
5. SEX Female 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married				8. DATE OF BIRTH Feb 18, 1906 9. AGE (In years last birthday) 59		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				11. BIRTHPLACE (State or foreign country) Balto. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis				14. MOTHER'S MAIDEN NAME Rose			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Wolf Palees 4016 Cold Spring Lane	
18. 443 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Starvation acidosis DUE TO (B) Hypertensive Ch.-disease DUE TO (C) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 19 50 to Dec. 7 19 65 , that (I) (we) last saw the deceased alive on 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Nathan B. Needle M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 12/8/65			
23C. PHYSICIAN'S NAME (Type) NATHAN B. NEEDLE M.D.				23D. ADDRESS 4215 Rad. Heights Ave. Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1965 Dec 8		24C. NAME OF CEMETERY or CREMATORY Beth Isaac Adath Israel		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1965		25B. NAME OF REGISTRAR R. E. F. F. F.		25C. FUNERAL DIRECTOR Sylvanus J. Lewis & Son, Inc.		ADDRESS 3319 Olympic Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

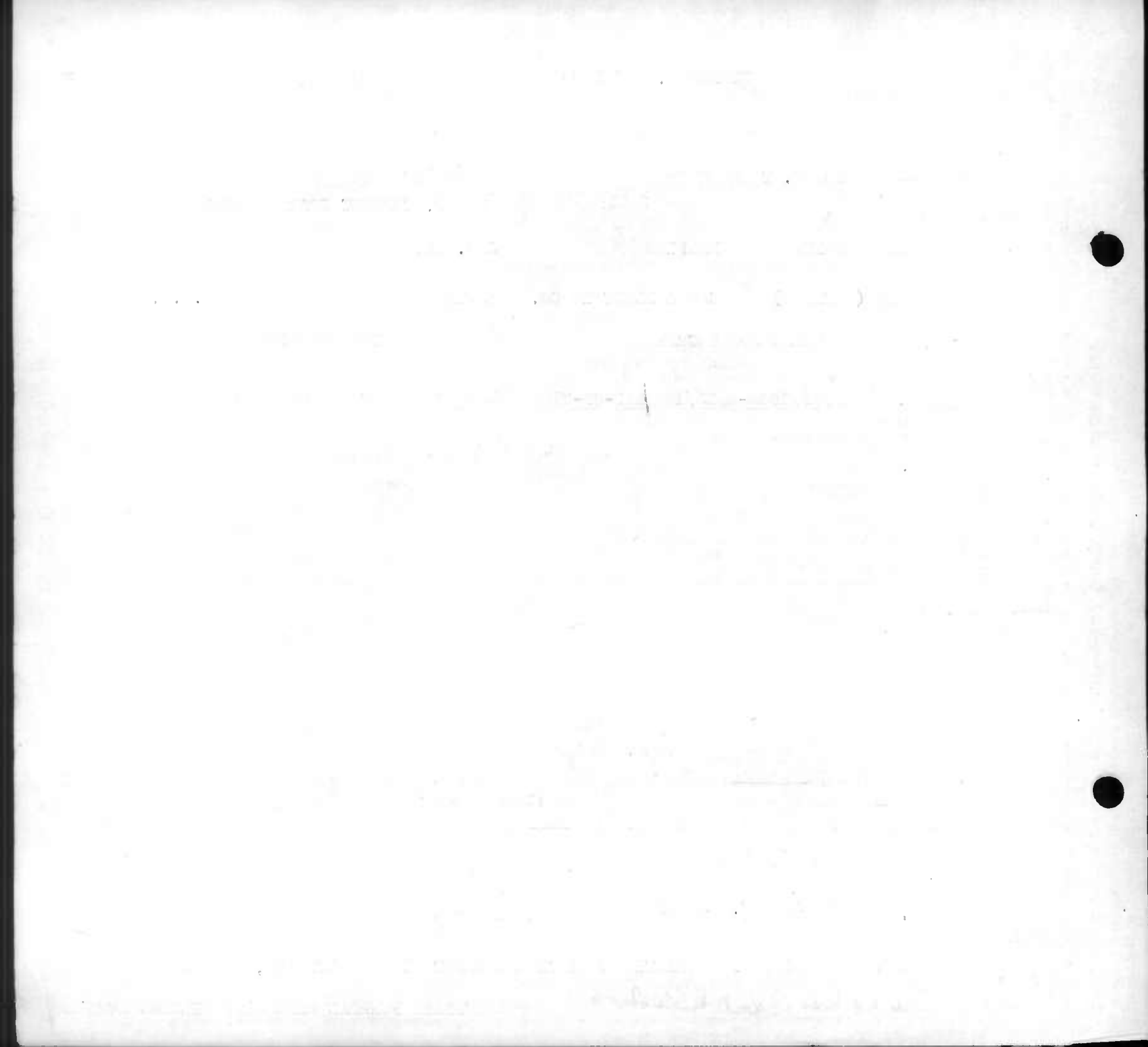
BALTIMORE CITY HEALTH DEPARTMENT											
BIRTH NO. M.E. CASE NO.		65 12571				CERTIFICATE OF DEATH				Registered No. 65 12571	
1. NAME OF DECEASED (Type or Print) ALMA CARROLL						2. DATE AND HOUR OF DEATH DECEMBER 7, 1965 6:00 P M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 806 SOUTH BEECHFIELD AVENUE					
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 1-26-18		9. AGE (In years last birthday) 47		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) KENTUCKY		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JAMES Grubbs						14. MOTHER'S MAIDEN NAME MAMIE AMUS					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 402-16-8504		17. INFORMANT AND CATON AVENUE ADDRESS ST. AGNES HOSPITAL RECORDS WILKENS					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						CAUSE OF DEATH Acute Pancreatitis Shock - Peritonitis				INTERVAL BETWEEN ONSET AND DEATH	
						(A) DUE TO					
						(B) DUE TO					
						(C) DUE TO					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from NOVEMBER 9 1965 to DECEMBER 7 1965 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DECEMBER 7 1965 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (I) (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.											
23A. SIGNATURE Steve L. Papastephanou M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 12/7/65		
23C. PHYSICIAN'S NAME (Type) STEVE PAPASTEPHANOU						23D. ADDRESS St. Agnes Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/11/65		24C. NAME OF CEMETERY OR CREMATORY Hurst Cemetery		24D. LOCATION (City, town, or county) (State) Middleboro Kentucky					
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1965				25B. NAME OF REGISTRAR Robert E. Feller		25C. FUNERAL DIRECTOR ADDRESS Walters Funeral Home Pratt & Strickland					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

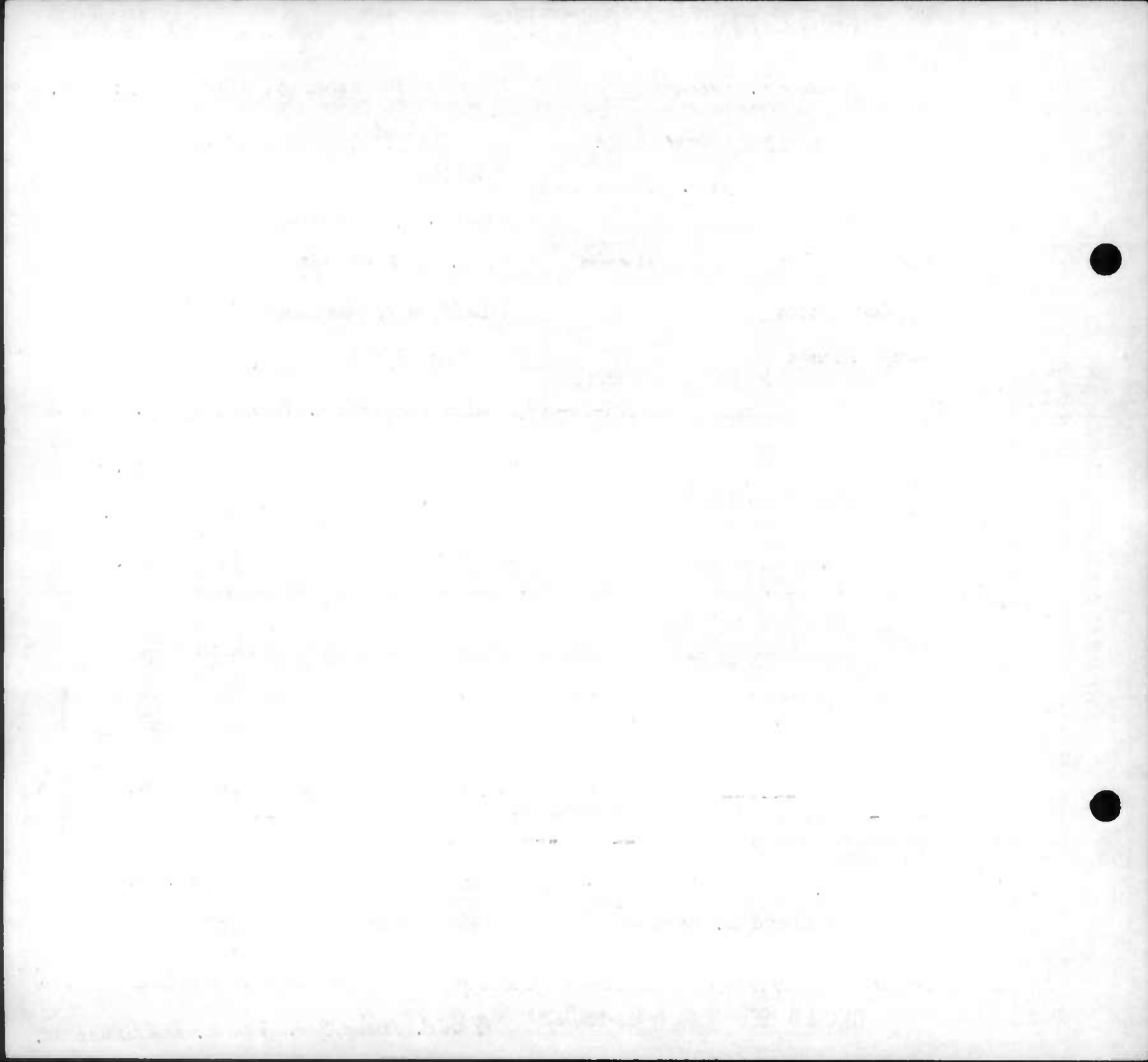
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 12572		CERTIFICATE OF DEATH		Registered No. 65 12572	
1. NAME OF DECEASED (Type or Print) HOWARD W. BUCKINGHAM				2. DATE AND HOUR OF DEATH 12/8/65 3.50 P M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 204 S. TREMONT ROAD 21229				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 28-09 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 204 S. TREMONT ROAD 21229					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH JAN. 12, 1896	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK (RETIRED)			10B. KIND OF BUSINESS OR INDUSTRY GAS & ELECTRIC CO.			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ELIAS BUCKINGHAM				14. MOTHER'S MAIDEN NAME MARY ALICE RECKARD					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) WW I 5/15/1918-6/26/1919				16. SOCIAL SECURITY NO. 1212-05-2706		17. INFORMANT ADDRESS MELVA SCHUBERT 116 TREMONT ROAD			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 443 X I Hypertensive + atherosclerotic CD Disease				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II CVA (2 yrs.) - Anemia secondary (6 mo.)									
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-16 1959 to 12-6 1965 , that (I) (we) lost saw the deceased alive on 12/3 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE John F. Schaefer				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/8/65			
23C. PHYSICIAN'S NAME (Type) JOHN F. SCHAEFER				23D. ADDRESS M.D. 401 RANDOM RD. - 21229					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/9/65		24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1965				25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR'S ADDRESS HUBBARD FUNERAL HOME 4107 WILKENS AVENUE # 29			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12573		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12573	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) Jerome M. Turner			2. DATE AND HOUR OF DEATH December 5, 1965 1:00 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 638 E. 37th Street			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 9-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 638 E. 37th Street		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Feb. 6, 1901	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Worker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME George Turner			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-16-1043		17. INFORMANT Miss Victoria M. Turner, 638 E. 37th St	
18. 422.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Chronic myocarditis INTERVAL BETWEEN ONSET AND DEATH 1 yr.			(A) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Syphillis, meningovascular, latent 5 yrs.			(B) DUE TO		
			(C) Acute and chronic cystitis 6 mo.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 19 65 to December 5, 19 65 , that (I) (we) last saw the deceased alive on December 1, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lloyd E. Saylor M.D.				23B. DATE SIGNED Dec. 6, 1965	
23C. PHYSICIAN'S NAME (Type) Lloyd E. Saylor				23D. ADDRESS 3902 Greenmount Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9/65		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION Baltimore, Maryland		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1965		25B. NAME OF REGISTRAR John A. Morgan, Inc.		25C. FUNERAL DIRECTOR 3000 C. Baltimore St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

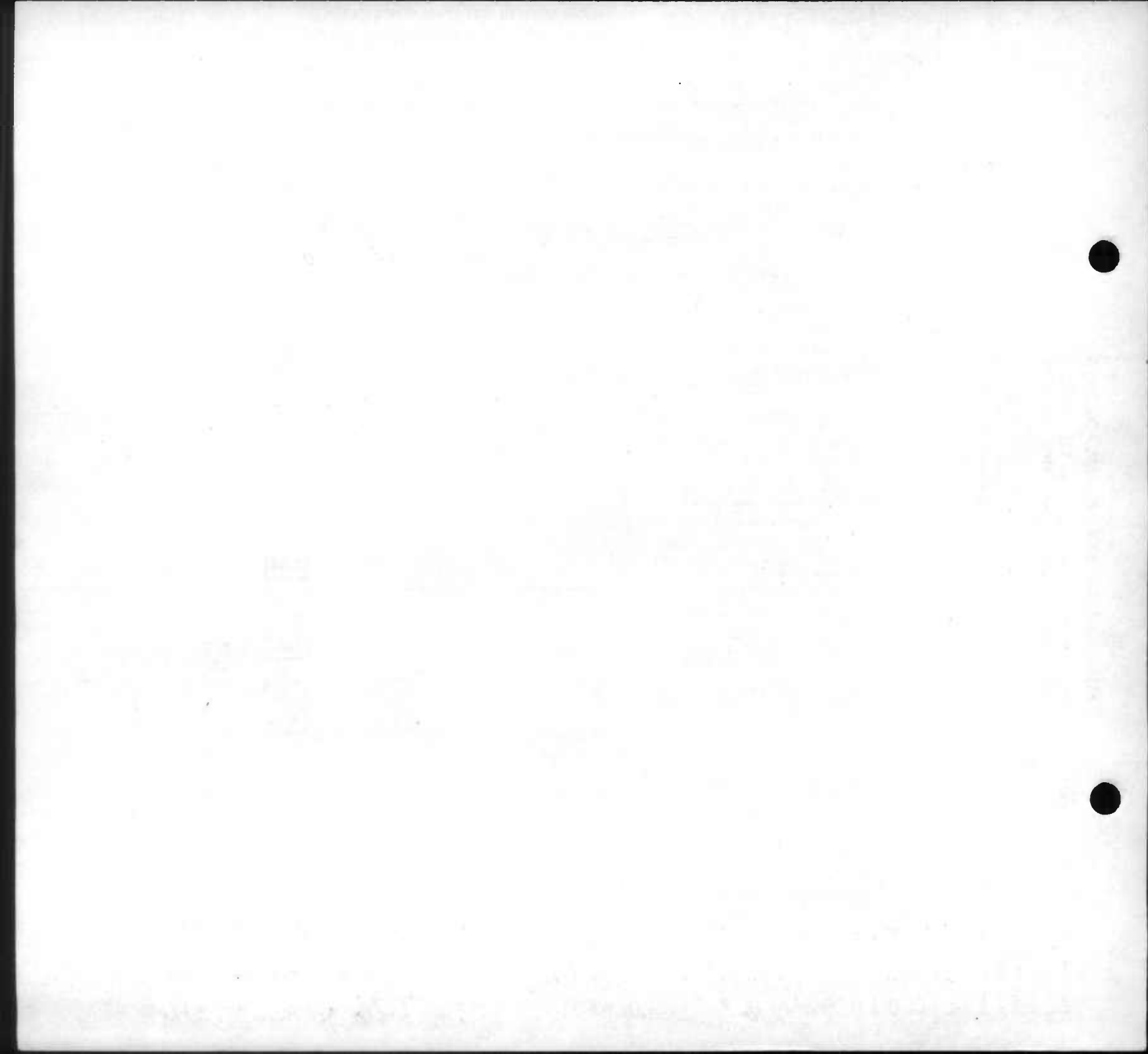
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 12574	
BIRTH NO. 65 12574							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) Sally Austin AKA SALLIE AUSTIN				2. DATE AND HOUR OF DEATH 12-8-65 6:30 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital				A. STATE MD. B. COUNTY 20-04			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 24 S. Catherine Street			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 8-29-1891	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10B. KIND OF BUSINESS OR INDUSTRY AT Home		11. BIRTHPLACE (State or foreign country) N. Carolina - Monique		12. CITIZEN OF WHAT COUNTRY? AMERICAN	
13. FATHER'S NAME John TORRENCE				14. MOTHER'S MAIDEN NAME CHERRY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Viola Harmon 2145. Catherine St	
18. 454 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) Anterior wall, thrombosis of iliac artery (B) Gen. arteriosclerosis (C)		? years	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute etiol 2 fibrinous peritonitis							
19A. DATE OF OPERATION Nov. 29, 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Rectal bleeding		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Nov. 14 19 65 to Dec. 8 19 65 , that (I) (we) last saw the deceased alive on Dec. 8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature] M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Dec. 8, 1965	
23C. PHYSICIAN'S NAME (Type) J. C. LINANTAD, JR. M.D.				23D. ADDRESS Bon Secours Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 12/10/65		24C. NAME OF CEMETERY or CREMATORY GREENWOOD		24D. LOCATION (City, town, or county) (State) NEW CASTLE PA.	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1965		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR [Signature]		ADDRESS 675 N 9th St	

Received of the
Hon. Secy. of the
Army \$100.00
July 10, 1911
W. H. C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 12575		CERTIFICATE OF DEATH		65 12575	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		FISHER, EDNA		DECEMBER 9, 1965 4 50 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
		3109 INDEPENDENCE ST. BALTIMORE 18 MD			
NORTH CHARLES GENERAL HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE 18 MD 9-05			
		D. STREET ADDRESS (If rural, give location)			
		3109 Independence St			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED (WIDOWED) DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)
F	W			NOV 23 1885	80
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		RETIRED		VIRGINIA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
M.W. FISHER		FISHER EMMA FERGUSON		U.S.A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				Marcellus Fisher 3109 Independence St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
451 X I		Ruptured aortic aneurysm CAUSE RECTUM PERFORATION		24 hr.	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2 NO				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 2:00 AM DEC 5 1965 to 4:50 AM DEC 5 1965, that (1) (we) last saw the deceased alive on 4:40 AM DEC 5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
W.H. Hawary				DEC. 5, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
THEODORE GRAZIANO		HARFORD RD #18			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12/11/65		Meadow Ridge	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 10 1965		R.E. FARMER		J.M. Jenkins 2713 Mt. Ave	



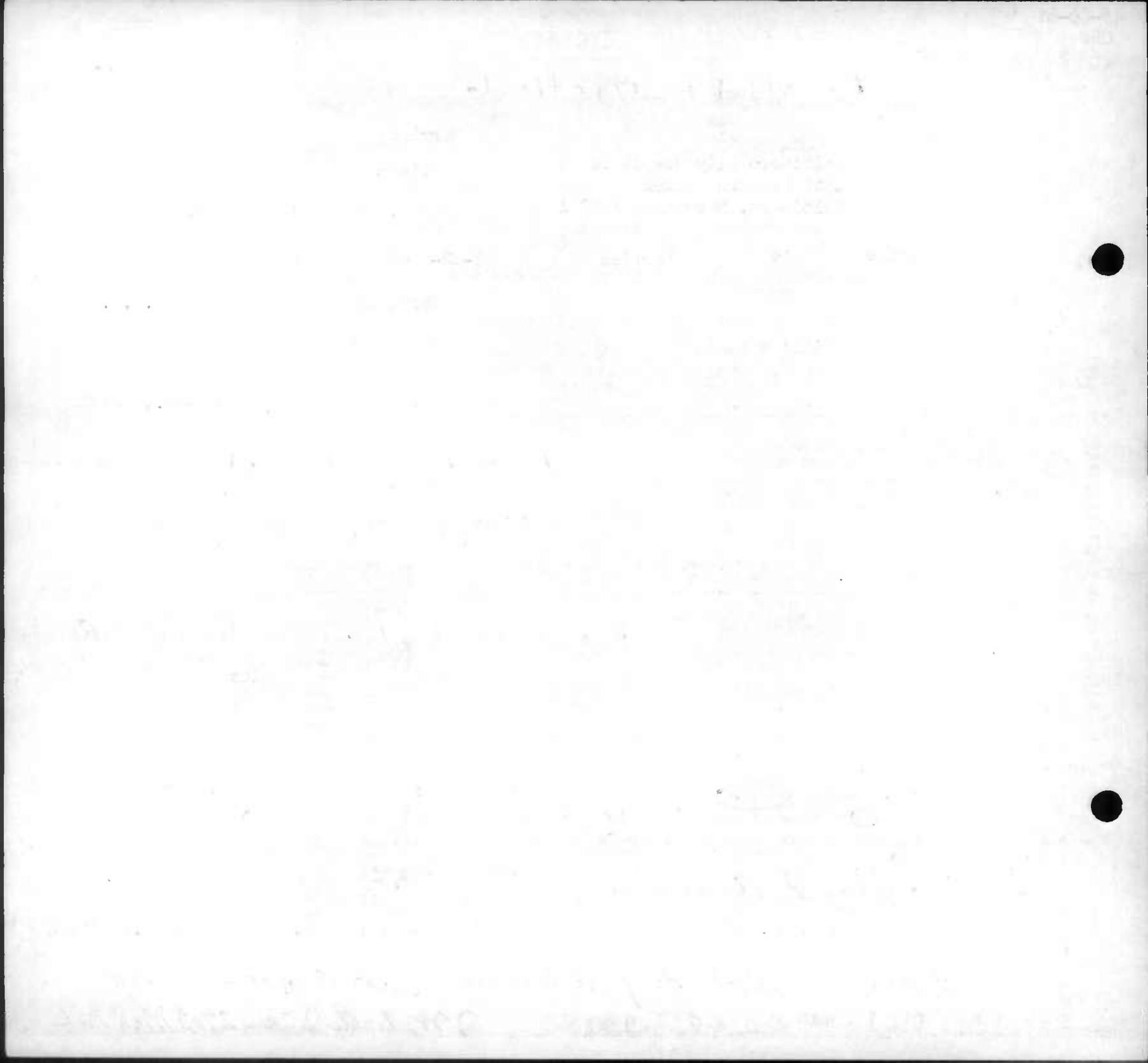
45-26-61

CRF

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. D-341 65 12576		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 12576	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Doettlaff, Myrtle G.				12-7-65 6 ⁰⁷ P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 9-07			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland, #21224				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 1523 E. 29th Street, #21218			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7-22-1889	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Butts				14. MOTHER'S MAIDEN NAME Mary Gonce			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH, 4940 Eastern Ave., #21224			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute Myocardial infarct - 9 hours 10h ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary artery atherosclerosis				CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diffuse cerebral arteriosclerosis = R							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from 11-22-65 19 65 to 12-7-65 19 65 , that (I) (we) last saw the deceased alive on 12-7-65 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jeffrey D. Aaronson				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-7-65	
23C. PHYSICIAN'S NAME (Type) JEFFREY D. AARONSON				23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Md., #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/11/65		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1965		25B. NAME OF REGISTRAR John Jenkins		25C. FUNERAL DIRECTOR John Jenkins		ADDRESS 2713 Hick Ave	



CERTIFICATE OF DEATH

Registered No. 65 12577

BIRTH NO. 65 12577

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21202

2. DATE AND HOUR OF DEATH

11/28/65 11 25 a.m.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1206 Central Avenue 21202

5. SEX

6. RACE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months: Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18. 760.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) DUE TO

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Not While
Work At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/27/65 to 11/28/65,
that (I) (we) last saw the deceased alive on 11/28/65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

M.D.

4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Cremated

11-30-65

Baltimore City Hospitals

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

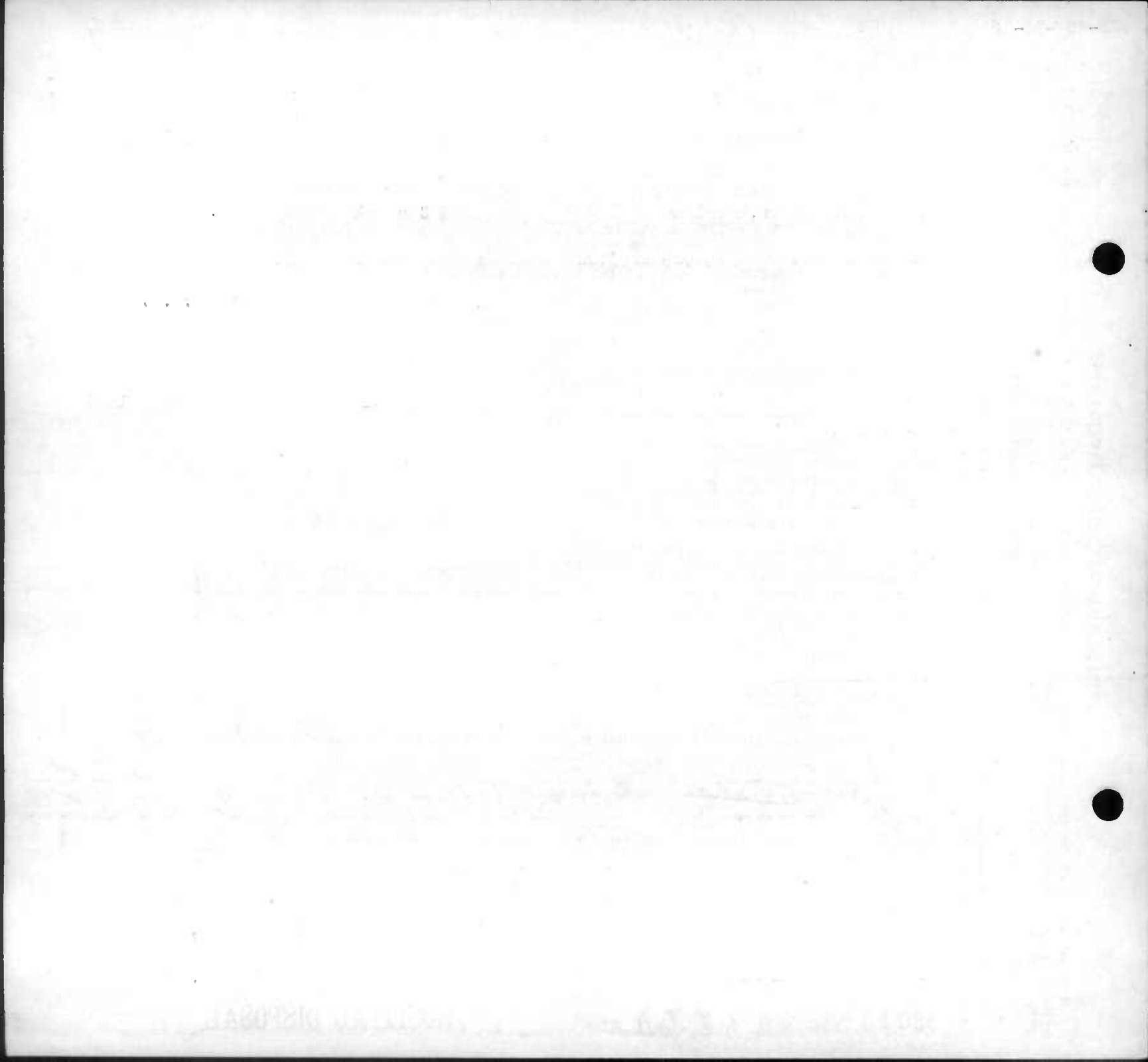
ADDRESS

DEC 10 1965

HOSPITAL DISPOSAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



65 12578

BALTIMORE CITY HEALTH DEPARTMENT

65 12578

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LOUIS M. GRAVES

2. DATE AND HOUR PRONOUNCED DEAD

December 8, 1965 8:05 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 21230

D. STREET ADDRESS (If rural, give location)

432 E. Clement Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct. 4, 1913

9. AGE (In years
last birthday)

35 52

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Bus Operator

10B. KIND OF BUSINESS OR INDUSTRY

Transit Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Peter D. Graves

14. MOTHER'S MAIDEN NAME

Daisy Airey

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

213 03-9993

17. INFORMANT Mrs. Mildred L.

Graves (Wife)

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/9/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Mon Dec 13 65

23C. NAME OF CEMETERY or CREMATORY

Cedar Hill Cem., Brooklyn, A.A.Co., Md.

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 10 1965

24B. NAME OF REGISTRAR

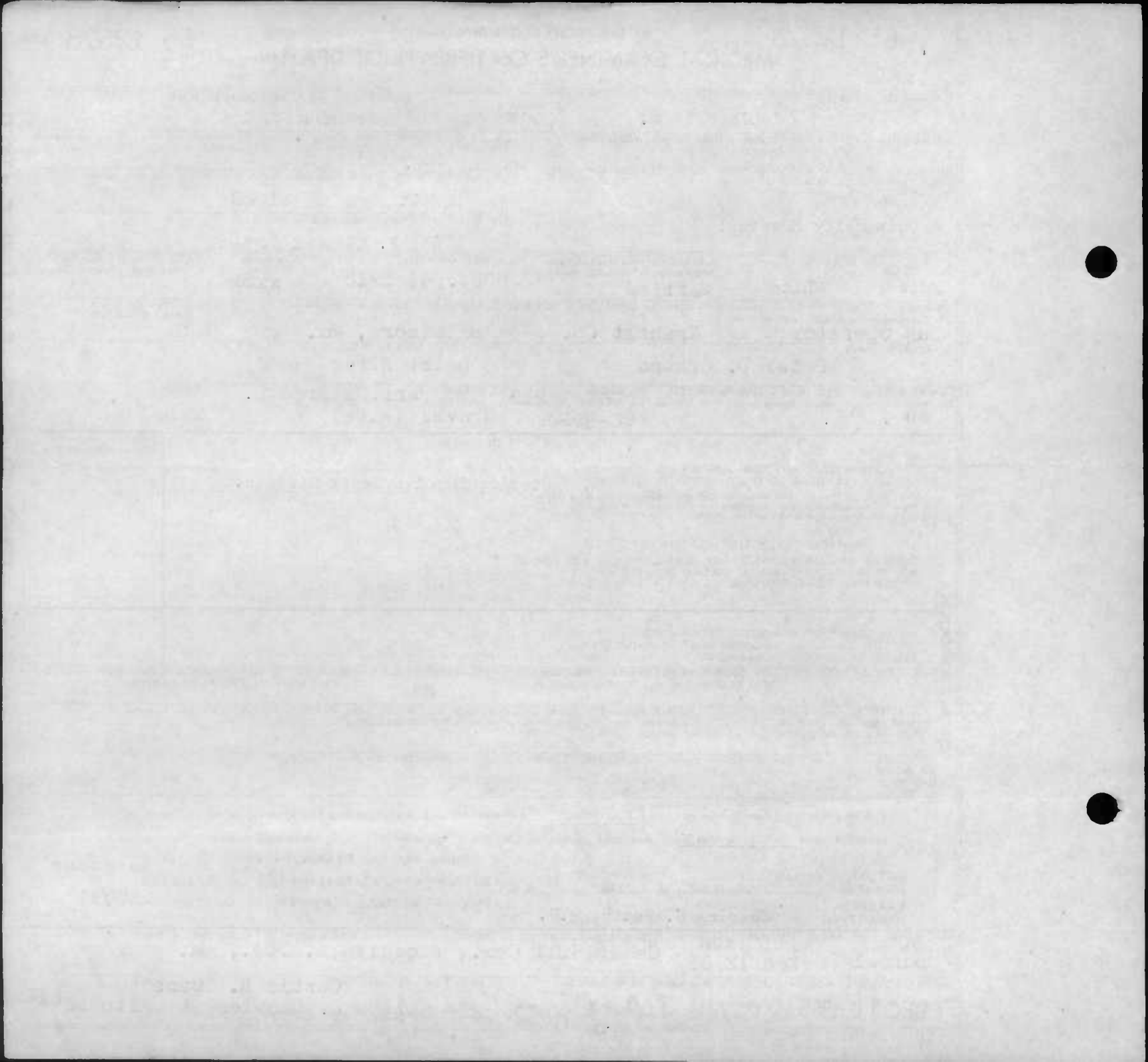
Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Curtis E. Evans

ADDRESS

1400 S. Charles St Balto Md 21230



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12579		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 12579	
1. NAME OF DECEASED (Type or Print) Bessie G. Hardesty				2. DATE AND HOUR OF DEATH 12-9-65 10:10 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1231 Roundhill Road				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 9-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1231 Roundhill Road			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 3-11-1887	9. AGE (in years last birthday) 78	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Virginia
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY Own Home		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Berry Garrison				14. MOTHER'S MAIDEN NAME Romenia O. Kellam			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-14-6168D		17. INFORMANT Mrs. Azalee H. Evans		ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CEREBRAL HEMMORHAGE (B) CHRONIC BRAIN SYNDROME (C) ARTERIO SCLEROSIS (GENERALIZED)				INTERVAL BETWEEN ONSET AND DEATH SUDDEN - 2 HRS 14 YEARS (?)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from SEPT. 1958 to DEC. 9, 1965, that (I) (we) last saw the deceased alive on NOV. 29, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Arthur Karfgin				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/10/65	
23C. PHYSICIAN'S NAME (Type) Dr. Arthur Karfgin				23D. ADDRESS M.D. 1532 Havenwood Road Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-11-65		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1965		25B. NAME OF REGISTRAR R. B. Jenkins		25C. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co.		ADDRESS 21212 York Road Balto.	

Chronic Pain Syndrome
Pain Management
Chronic Pain Management

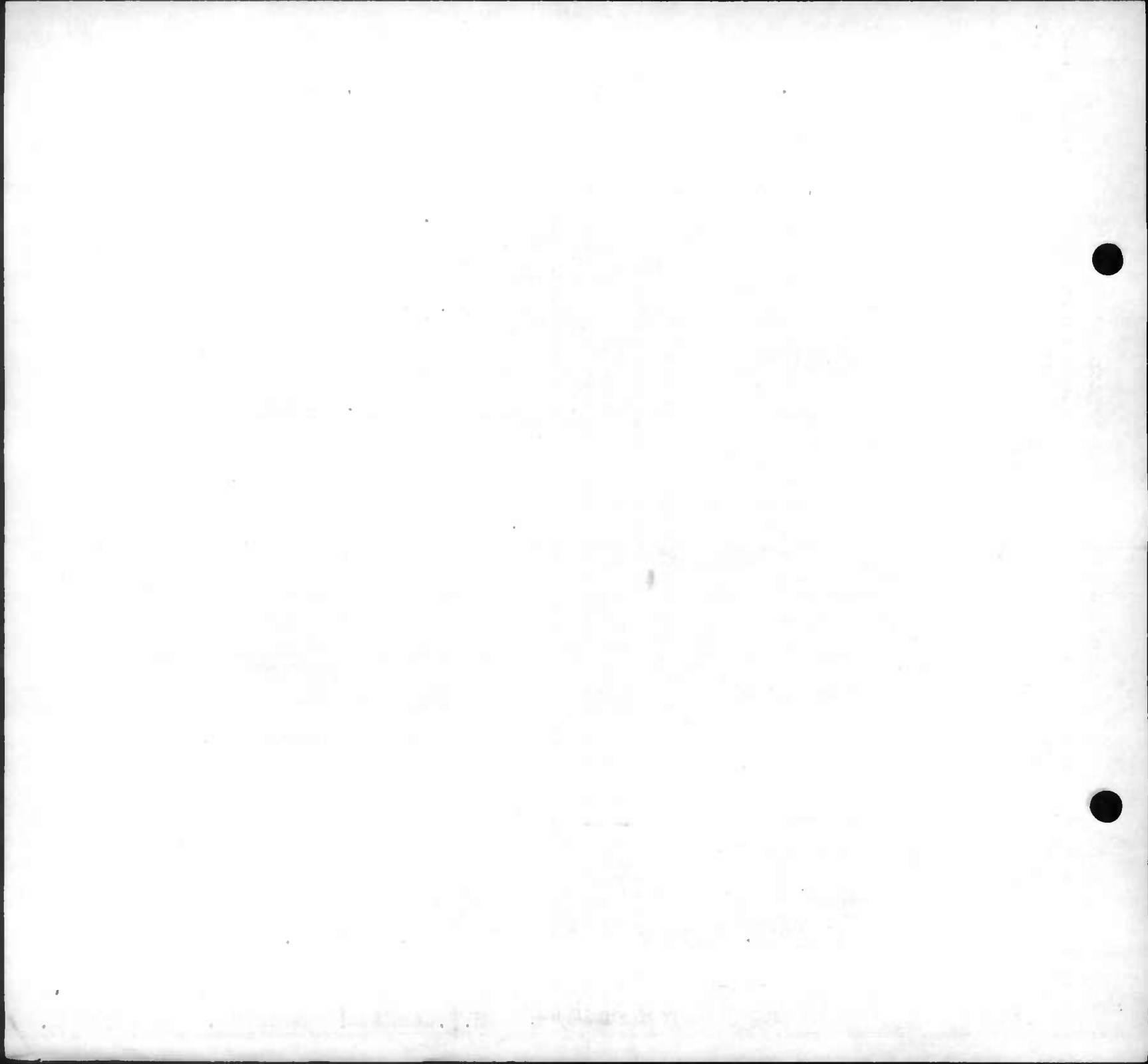
Nov 2011
Dec 11

Chronic Pain

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 12580					CERTIFICATE OF DEATH		Registered No. 65 12580		
1. NAME OF DECEASED (Type or Print) L. Vernon Miller					2. DATE AND HOUR OF DEATH Dec. 8, 1965 18 7 M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-11				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 11 W. Cold Spring Lane					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
D. STREET ADDRESS (If rural, give location) 11 W. Cold Spring Lane									
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5-29-1884	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer			10B. KIND OF BUSINESS OR INDUSTRY Law		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? D		
13. FATHER'S NAME DeCatur Miller					14. MOTHER'S MAIDEN NAME Agnes Owens				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Katherine B. Miller		ADDRESS Above		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) DUE TO Cerebral Arteriosclerosis (B) DUE TO Hypertension (C) Coronary Arteriosclerosis Paralysis / Heart Block					INTERVAL BETWEEN ONSET AND DEATH				
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Nov 1 1965 to Dec 8 1965, that (I) (we) last saw the deceased alive on Dec 8 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Walter A. Baetjer M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 12/9/65	
23C. PHYSICIAN'S NAME (Type) Walter A. Baetjer					23D. ADDRESS M.D. 1010 St. Paul St.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-11-65		24C. NAME OF CEMETERY or CREMATORY Druid Ridge		24D. LOCATION (City, town, or county) Pikesville		24E. STATE Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1965		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd.					



65 12581

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 12581

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDWARD BRANCH

2. DATE AND HOUR PRONOUNCED DEAD

12-6-65

2:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

526 N. EUTAW STREET

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

526 N. Eutaw Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Separated

8. DATE OF BIRTH

1/5/1900

9. AGE (In years /
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

?

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Margaret Carter 413 Roberts St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A).....
DUE TO

Hypertensive cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B).....
DUE TO

(C).....

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

CHARLES S. PETTY

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-6-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/10/65

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cemetery

23D. LOCATION

(City, town, or county)

A A County Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 10 1965

24B. NAME OF REGISTRAR

Robert E. [Signature]

24C. FUNERAL DIRECTOR

Adolphus Halstead

ADDRESS

1206 W North Ave

VALLEY FORD

MEMORANDUM

TO : MR. NICHOLS

FROM : MR. TOLSON

SUBJECT : [illegible]

DATE : [illegible]

RE : [illegible]

BY : [illegible]

FOR : [illegible]

THAT : [illegible]

AND : [illegible]

WHICH : [illegible]

AND : [illegible]

AND : [illegible]

1
H 452

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

65 12582

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 12582

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE W. HOLMES

2. DATE AND HOUR PRONOUNCED DEAD

December 8, 1965

12:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

REDENCE

1224 E. Madison Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1224 E. Madison Street

5. SEX

male

6. RACE

negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

7. 10. 1918

9. AGE (In years
last birthday)

47

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

COOK

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

GUY HOLMES

14. MOTHER'S MAIDEN NAME

NETTIE FLETCHER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

215.12.1857

17. INFORMANT

ADDRESS

JIMMY G. HOLMES 701 W. MULBERRY ST.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Chronic pulmonary emphysema

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes-Partial

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?
yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-8-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

12 13 65

23C. NAME of CEMETERY or CREMATORY

MT. CALVARY

23D. LOCATION

(City, town, or county)

A.A. COUNTY MD.

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 10 1965

24B. NAME OF REGISTRAR

Robert E. Smith, M.D.

24C. FUNERAL DIRECTOR

JOSEPH KNIGHT

ADDRESS

1639 N. BROADWAY

1810

Released by Med Examiner with approved. *Dryden, M.D.*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12583		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12583	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) DOROTHY ANNETTE GROSS		2. DATE AND HOUR OF DEATH DECEMBER 7, 1965 4:45 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3320 CHERRYLAND ROAD			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 11-23-41	9. AGE (In years last birthday) 24	If Under 1 Yr. Months: Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY DEPT. VOC. REHAB.		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOHN GROSS		14. MOTHER'S MAIDEN NAME MARY JORDAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-10-2652		17. INFORMANT MARY GROSS - Mother - Rt #1 Bx 2978 GLEN BURNIE Md	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease or injury or complication which caused death.) DISEASE OR CONDITION CAUSING IT: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH Acute subarachnoid hemorrhage of intracerebral hematoma MIDBRAIN COMPRESSION Aneurysm of right ant. cerebral artery UNCAL HERNIATION ACUTE SUBDURAL HEMATOMA		INTERVAL BETWEEN ONSET AND DEATH 5 days unknown 5 days 5 days	
19A. DATE OF OPERATION B 12-2-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INCREASED I.C. PRESSURE BRAIN STEM HERNIATION		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner) No		21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 11/30 19 65 to 12/7 19 65, that (X) (we) last saw the deceased alive on 12-7- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ivan L. Butler				23B. DATE SIGNED 12/7/65	
23C. PHYSICIAN'S NAME (Type) IVAN L. BUTLER				23D. ADDRESS M.D. UNIVERSITY HOSPITAL BALTO. MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-11-65		24C. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PK.	
24D. LOCATION (City, town, or county) ARBUTUS MD.		24E. STATE (State) MD.			
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1965		25B. NAME OF REGISTRAR J. L. BROWN		25C. FUNERAL DIRECTOR J. L. BROWN	
25D. ADDRESS 1501 123 W. MONTGOMERY ST.					

11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 12584</u>	
BIRTH NO. <u>65 12584</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Anna Robinson</u>		2. DATE AND HOUR OF DEATH <u>November 30, 1965</u> <u>4:30A</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>534 Oxford Street</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>12-2-98</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H-W</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
13. FATHER'S NAME <u>Arron Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Cassie</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Doris Clash 534 Oxford Street</u>	
18. <u>199.2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Metastatic Carcinoma</u> (B) <u>Anemia</u> (C) <u>Cachexia</u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>November 28, 1965</u> to <u>November 30, 1965</u> , that (I) (we) last saw the deceased alive on <u>November 30, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. Theodore</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>November 30, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Theodore</u>		23D. ADDRESS M.D. <u>1514 Division Street</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-4-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn Cemetery</u>	
		24D. LOCATION (City, town, or county) (State) <u>Baltimore City</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 10 1965</u>		25B. NAME OF REGISTRAR <u>Isaiah T. Brown and Son</u>		25C. FUNERAL DIRECTOR ADDRESS <u>108 W. Montgomery Street</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 12585</u>	
BIRTH NO. <u>65 12585</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Mrs. Lolo Moore</u>		2. DATE AND HOUR OF DEATH <u>Dec 8, 1965</u> <u>1 530</u> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>14-01</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore - 17</u> D. STREET ADDRESS (If rural, give location) <u>1623 Bolton St</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Park Hill Convalescent Home</u>					
5. SEX <u>F</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12/1/1878</u>	9. AGE (In years last birthday) <u>87</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William T. Downs</u>		14. MOTHER'S MAIDEN NAME <u>Louisane ?</u>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. John T. Moore</u> ADDRESS <u>8725 Old Harford Rd.</u>	
18. <u>334X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Chronic Brain Disease</u> DUE TO (B) <u>Generalized Art Sclerosis</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>sev. years</u> <u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Oct 30</u> 19 <u>58</u> to <u>Dec 8</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Dec 8</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Louis V. Blum, M.D.</u>				23B. DATE SIGNED <u>12/8/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Louis V. Blum, M.D.</u>				23D. ADDRESS <u>3502 W. Rogen Ave Balto 9, Md</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/11/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greensboro</u>	
				24D. LOCATION (City, town, or county) (State) <u>Greensboro, Caroline Co. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 10 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. [Signature]</u>		25C. FUNERAL DIRECTOR <u>Wm. J. [Signature]</u> ADDRESS <u>W. & Pa. Ave Balto. Md. - 21217</u>	

1871
1872

1873
1874

1
B650

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 12586 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12586

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ROBERT WASHINGTON BROWN Jr.				2. DATE AND HOUR PRONOUNCED DEAD 12-8-65 1:00 P			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Provident Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-01			
FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 1550 Leslie St.			
5. SEX male	6. RACE negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Jan. 7, 1926		9. AGE (In years last birthday) 39	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Robert W. Brown Sr.				14. MOTHER'S MAIDEN NAME Bertie Watkins			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Bertie Brown 1717 N. Pulaski St.				
18. CAUSE OF DEATH E981X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Gunshot wounds of abdomen (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 12-4-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) house		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1601 Fulton Ave.			
21D. TIME OF INJURY (APPROX.) 12-4-65 12:10A		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? shot during altercation			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-8-65 ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Rudiger Breiteneker, M.D. EXAMINER'S NAME (Type)							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 12/13/65		23C. NAME of CEMETERY or CREMATORY Balto. Natl. Cem.		23D. LOCATION (City, town, or county) (State) Baltimore, Md.	
24A. DATE REC'D BY HEALTH DEPT. DEC 10 1965		24B. NAME OF REGISTRAR R. E. Tolson		24C. FUNERAL DIRECTOR ADDRESS 1348 N. Calhoun St			

N879-4

VALLEY FORGE

WASHINGTON, D.C.

January 1, 1950

Dear Sir:

Robert W. Brown Jr.

Robert W. Brown Jr.

Robert W. Brown Jr.

Very truly yours,

Respectfully,

Robert W. Brown Jr.

Enclosed

BIRTH NO.

65 12587

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 12587

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LUCILLE

DELOATCH

2. DATE AND HOUR PRONOUNCED DEAD

December 9, 1965

5:05 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

613 N. Carrollton Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

7-22-23

9. AGE (In years
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Miller Newsome

14. MOTHER'S MAIDEN NAME

Rosary Vaughn

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Pelastine Mitchell 604 Pulaski St

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Fatty Liver and Cirrhosis.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/9/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 10 1965

9 6 5 0 0 1

1348 N. Calhoun St

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

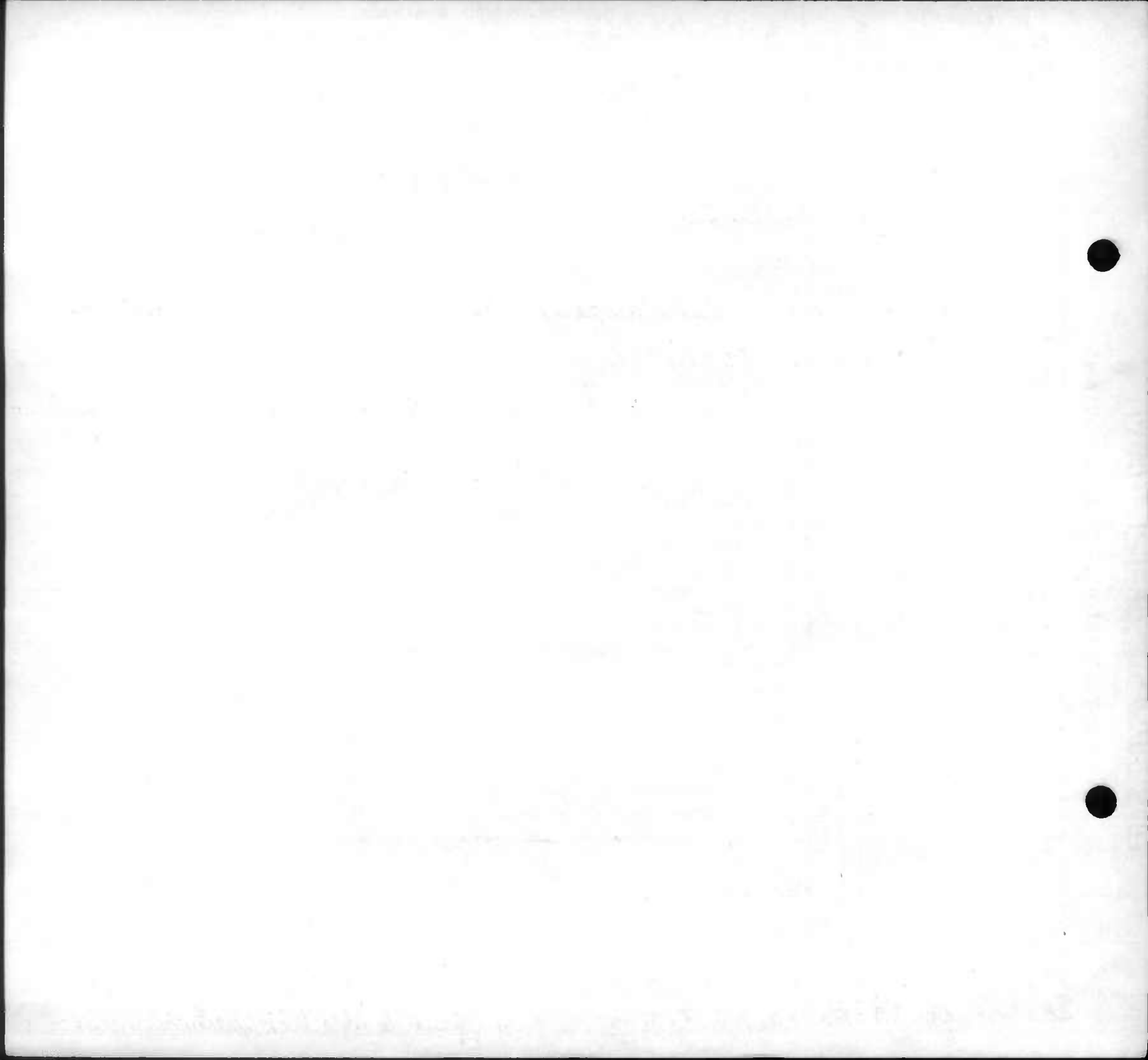
BIRTH NO. 65 12588		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12588	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) YORI BEATRICE		2. DATE AND HOUR OF DEATH 12/7/65 4:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 43 1519 South Baltimore General Hosp.		A. STATE Maryland B. COUNTY 3-01			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore # 21230			
		D. STREET ADDRESS (If rural, give location) 1519 Bank St.			
5. SEX F.	6. RACE W.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow.	8. DATE OF BIRTH 7-26-1891	9. AGE (In years last birthday) 74	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Keeper		10B. KIND OF BUSINESS OR INDUSTRY Grocery XXXXXX		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? Italy		13. FATHER'S NAME Faust Pannoni			
14. MOTHER'S MAIDEN NAME Natalie		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 212 348 804		17. INFORMANT DI ANGELO ADDRESS MRS-NATALIE YORI 1519 Bank St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 422.1		CAUSE OF DEATH (A) Conjunctive Heart failure (B) Arteriosclerotic cardiovascular disease (C)			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 12-5 19 65 to 12-7 19 65 , that the (we) last saw the deceased alive on 12-7 19 65 and that in our (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert R. Holthaus M.D.				23B. DATE SIGNED 12/7/65	
23C. PHYSICIAN'S NAME (Type) ROBERT R. HOLTHAUS, M.D.				23D. ADDRESS South Balto. Gen. Hosp. - 1213 Light St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/11-65		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem.	
24D. LOCATION (City, town, or county) (State) 4430 Belair Rd. Balt. Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 10 1965			
25B. NAME OF REGISTRAR John Della Noce		25C. FUNERAL DIRECTOR ADDRESS 322 S. High St.			

THE UNIVERSITY OF CHICAGO
LIBRARY
1000 S. MICHIGAN AVE.
CHICAGO, ILL. 60607
TEL. 733-7321

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12589				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12589	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Emmett W. Robinson				2. DATE AND HOUR OF DEATH 12-9-65 7:10 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 8-07	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				D. STREET ADDRESS (If rural, give location) 1609 E. Preston St.			
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 10-27-1896	9. AGE (In years last birthday) 69	10. Under 1 Yr. Months: Days:	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Flagman		10B. KIND OF BUSINESS OR INDUSTRY R.R. Company		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William W. Robinson				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 717-05-3962		17. INFORMANT Mrs. Mary Scott			
18. 260X I		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		ANTECEDENT CAUSES		(A) DUE TO ARTERIO SCLEROTIC HEART		Sudden	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO DIABETES MELLITUS		(C) DUE TO		5 YRS.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2-13-62 19 to 12-9-65 19, that (I) (we) last saw the deceased alive on 12-3-65 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Maurice Adams				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-10-65	
23C. PHYSICIAN'S NAME (Type) MAURICE L. ADAMS				23D. ADDRESS 238 N. CARREY ST Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-13-65		24C. NAME OF CEMETERY or CREMATORY MT. AUBURN CMTY.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1965		25B. NAME OF REGISTRAR R. E. Adams		25C. FUNERAL DIRECTOR Randolph J. Collick			
				ADDRESS 1420 E. Preston St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12590		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 12590	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Zebb Cannon or Zeb CANNON		2. DATE AND HOUR OF DEATH 12-7-65 1200 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1612 E. Lafayette Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9-22-01	9. AGE (In years last birthday) 64	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Refining Co.		11. BIRTHPLACE (State or foreign country) Pick Co., N.C.	
13. FATHER'S NAME Benny Cannon		14. MOTHER'S MAIDEN NAME Penny Burney			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-096260		17. INFORMANT PENNIE CANNON 1612 Lafayette Ave.	
18. 443 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Intracerebral hemorrhage DUE TO 14 hours (B) Hypertensive CV Disease DUE TO 3+ years (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 7 1965 to December 7 1965, that (I) (we) last saw the deceased alive on Dec 7 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. Leigh Thompson				23B. DATE SIGNED Interne Dec 7, 1965	
23C. PHYSICIAN'S NAME (Type) W. Leigh Thompson		23D. ADDRESS Osler Service, Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-11-65		24C. NAME OF CEMETERY or CREMATORY Carver Memorial PK.	
24D. LOCATION Laurel, Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 10 1965			
25B. NAME OF REGISTRAR R. E. Thompson		25C. FUNERAL DIRECTOR Randolph J. Collick 1426 E. Preston St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
65 12591						65 12591					
BIRTH NO.						Registered No.					
1. NAME OF DECEASED (Type or Print) <i>Marie Schnaufer</i>						2. DATE AND HOUR OF DEATH <i>12-7-65 9³⁰ P.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>102</i>					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>48 Maryland General Hospital</i>						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balti. mode 24</i>					
						D. STREET ADDRESS (If rural, give location) <i>519 S. Curley St.</i>					
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>9-8-1882</i>	9. AGE (In years last birthday) <i>83</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>John Ziers</i>						14. MOTHER'S MAIDEN NAME <i>Mary Clark</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>unk</i>						16. SOCIAL SECURITY NO. <i>?</i>		17. INFORMANT ADDRESS <i>Hospital Chart</i>			
18. <i>422.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						CAUSE OF DEATH (A) DUE TO <i>Arteriosclerotic Cardiovascular Disease, generalized, marked</i> (B) DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <i>12.1.1965</i> to <i>12.7.1965</i> , that (I) (we) last saw the deceased alive on <i>12.7.1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>[Signature]</i>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>12-7-65</i>			
23C. PHYSICIAN'S NAME (Type) <i>[Signature]</i>						23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>12-10-65</i>		24C. NAME of CEMETERY or CREMATORY <i>New Cathedral Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 10 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. [Signature]</i>		25C. FUNERAL DIRECTOR <i>B. Dubro [Signature]</i>		ADDRESS <i>41284 F. Baltimore St.</i>					



BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12592

BIRTH NO. 65 12592

M.E. CASE NO. 65 12592

1. NAME OF DECEASED (Type or Print) ANTHONY J. TAMBERINO Sr.		2. DATE AND HOUR PRONOUNCED DEAD December 8, 1965 1:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____ C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-01 D. STREET ADDRESS (If rural, give location) 3107 Tyndale Avenue	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Sept. 24, 1904.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed		10B. KIND OF BUSINESS OR INDUSTRY Produce Business	9. AGE (In years last birthday) 61
13. FATHER'S NAME Frank Tamberino		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-32-7548	
17. INFORMANT Angela Tamberino		ADDRESS (Same)	
18. 420.1 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Artery Thrombosis and Myocardial Infarction due to Arteriosclerotic Cardiovascular Disease. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) INDEXED (B) DUE TO _____ (C) _____			INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 12/9/65			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 12/11/65.	
23C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		23D. LOCATION (City, town, or county) (State) Baltimore, Md.	
24A. DATE REC'D BY HEALTH DEPT. DEC 10 1965		24B. NAME OF REGISTRAR Robert E. F...	
24C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		ADDRESS Balto. Md. 21214	

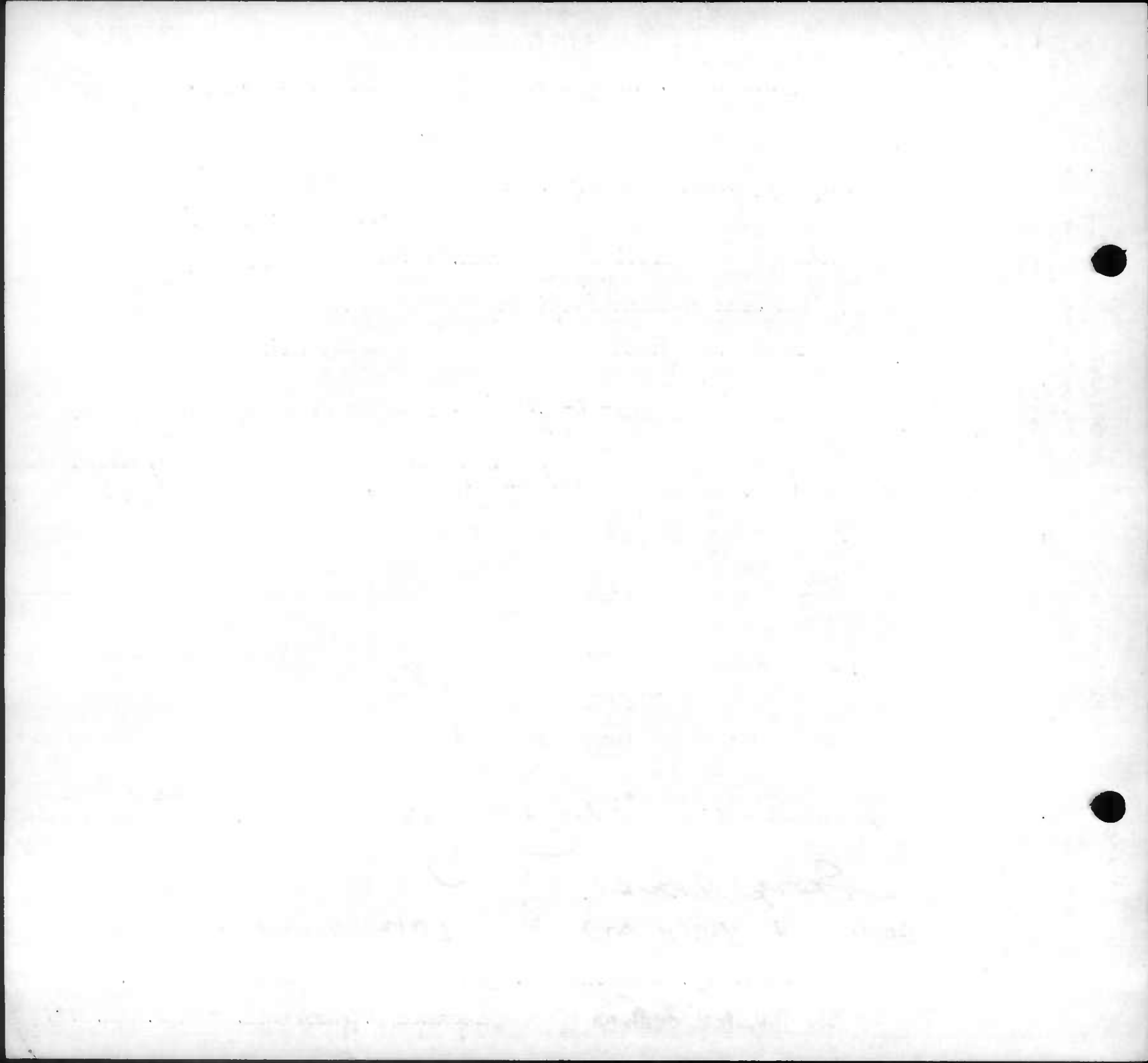
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WALTER D. FORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 12593	
BIRTH NO. 65 12593		M.E. CASE NO. 65 12593		1. NAME OF DECEASED (Type or Print) Charles W. Traugher		2. DATE AND HOUR OF DEATH December 8, 1965. 6:32 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harford Gardens Nursing Home				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 27-38			
5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married				8. DATE OF BIRTH May 2, 1886		9. AGE (In years last birthday) 79	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired American Smelting & Refining		10B. KIND OF BUSINESS OR INDUSTRY Missouri		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Traugher				14. MOTHER'S MAIDEN NAME Maria Bryson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 285-01-2512		17. INFORMANT Mrs. Georgia P. Traugher		ADDRESS (Same)	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CVA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral Arteriosclerosis				(A) DUE TO CVA (B) DUE TO Cerebral Arteriosclerosis (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 9 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1960 to Dec 8th 1965 , that (I) (we) last saw the deceased alive on Dec 8th 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE George H. Beck MD				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/10/65	
23C. PHYSICIAN'S NAME (Type) GEORGE H. BECK MD		23D. ADDRESS 6012 Harford Rd. Baltimore, Md. 21214					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/11/65		24C. NAME of CEMETERY or CREMATORY Moreland Mem. Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1965		25B. NAME OF REGISTRAR Leopold J. Ruck Inc.		25C. FUNERAL DIRECTOR ADDRESS Balto. Md. 21214			



65 12594

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12594

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)~~KOSTADINOS SIGANOS~~ KOSTANDINOS SIGANOS

2. DATE AND HOUR PRONOUNCED DEAD

December 8, 1965 10:10 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION
(If not in hospital or institution, give street
address or location)

City Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

14 S. Highland St. A venue

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Aug. 23, 1958

9. AGE (in years
last birthday)

7

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John K. Siganos

14. MOTHER'S MARDEN NAME

Angeleke
Angeleke Demos15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

John Siganos

ADDRESS

(Same)

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple traumatic injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Lombard St. and Highland Ave.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12-3-65 11:45 A

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-8-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/13/65

23C. NAME OF CEMETERY or CREMATORY

Greek Orthodox Cemetery

23D. LOCATION

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 10 1965

24B. NAME OF REGISTRAR

R. E. H. 29-36-05-00

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc.

ADDRESS

Balto. Md. 21214

VALLEY FORCE

RAB CONTENT

A. H. S. A.

12-14-65

Quintanilla

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

65 12595

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12595

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN

N.

KOUNELIS

2. DATE AND HOUR PRONOUNCED DEAD

December 9, 1965

10:53 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3004 Fleetwood Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Feb. 20, 1903

9. AGE (in years
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

(Capt. Waiters

10B. KIND OF BUSINESS OR INDUSTRY

Hotel

11. BIRTHPLACE (State or foreign country)

Greece

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Nicholas Kounelis

14. MOTHER'S MAIDEN NAME

Julia ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Helen Kounelis

ADDRESS

(Same)

18.

E 812.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) DUE TO Hemorrhagic Softening of Brain and Bronchopneumonia
Thrombosis, with complete occlusion
of right common carotid artery
(B) DUE TO Extreme hyperextension of neck, with fracture of body
of C4 and hemorrhage into atherosclerotic plaque.
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Atherosclerosis of right carotid artery.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Baltimore and Calvert Streets

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12 5 '65 P

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/9/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/11/65.

23C. NAME OF CEMETERY or CREMATORY

Greek Orthodox Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 10 1965

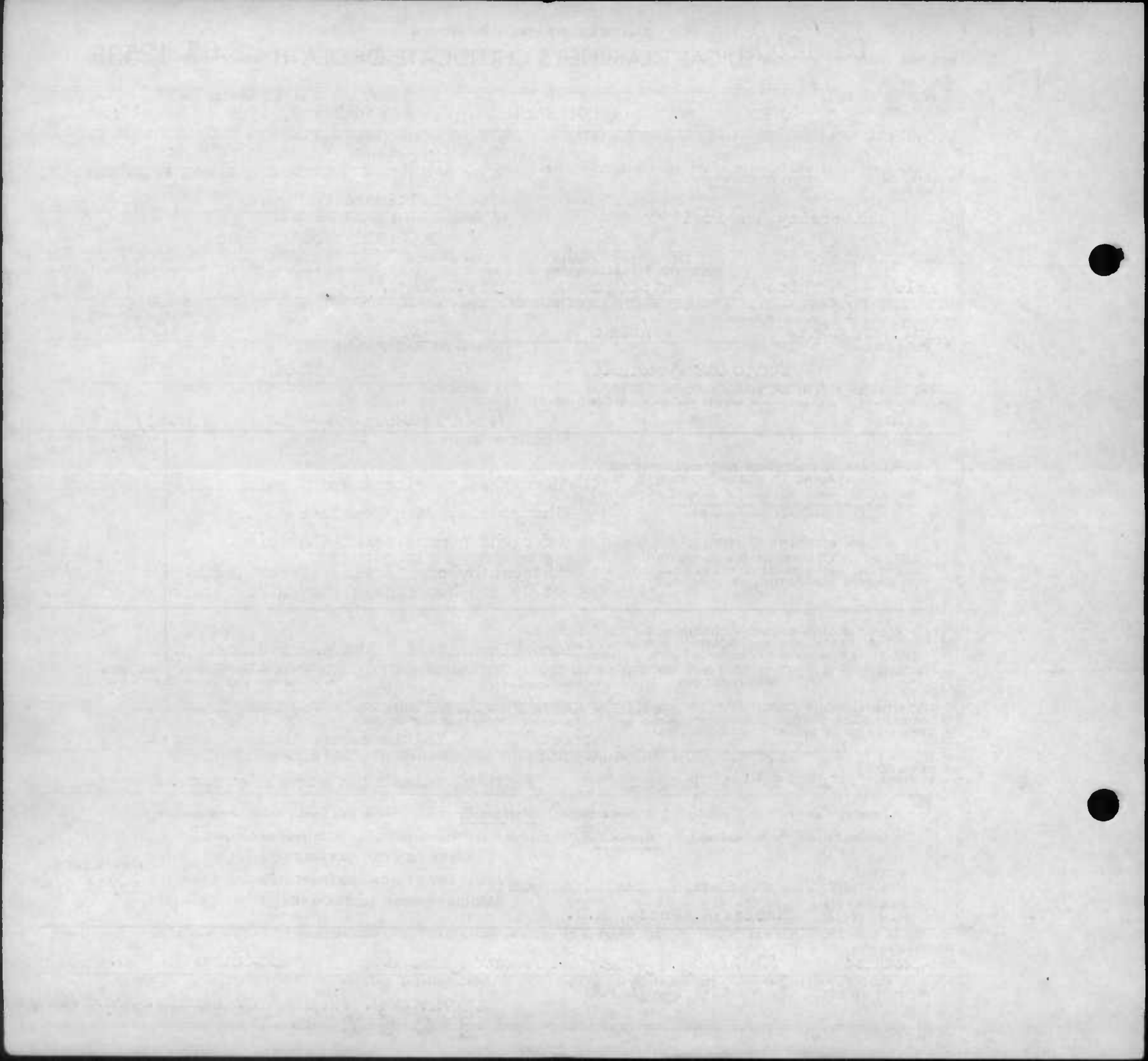
24B. NAME OF REGISTRAR

Robert E. Petty, M.D.

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. Balto. Md. 21214

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12596	
BIRTH NO. 65 12596		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mr. Getz, JOHN BERNARD		2. DATE AND HOUR OF DEATH 1965. 12. 9. 11.45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore B. COUNTY REES ST.			
FULL NAME OF HOSPITAL OR INSTITUTION The Union Memorial Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 2718 REESE ST.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 7-29-99	9. AGE (in years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY House of Getz		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? America		13. FATHER'S NAME JOHN C. Getz		14. MOTHER'S MAIDEN NAME Cecilia powers	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-05-7751		17. INFORMANT Mrs. Frieda Getz	
18. 578 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Perforation of bowels and infection.		CAUSE OF DEATH (A) DUE TO		ADDRESS (Same)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-5 65 19 65 to 12-9 19 65 , that (I) (we) last saw the deceased alive on 12-9 , at 1.45 AM 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Pyong IL KWON M.D.				23B. DATE SIGNED 12-9 '65	
23C. PHYSICIAN'S NAME (Type) PYOUNG IL KWON M.D.				23D. ADDRESS The Union Memorial Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/13/65		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214	

PLATE 11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 12597		CERTIFICATE OF DEATH				Registered No. 65 12597			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOSEPH CROKAMO (Crocamo)				2. DATE AND HOUR OF DEATH 12-9-65 12:25 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 7 MERCY HOSPITAL		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY 12-07			
				C. CITY OR TOWN BALTIMORE		(If outside city limits, write RURAL and give township)			
				D. STREET ADDRESS 2440 MARYLAND AVE.		(If rural, give location)			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 10-20-1895	9. AGE (In years last birthday) 70	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		11. BIRTHPLACE (State or foreign country) ITALY	
		10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME RALPH CROKAMO					14. MOTHER'S MAIDEN NAME FRANCES GABRIEL				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 165-18-0415		17. INFORMANT Mrs. Elvira Crokamo			ADDRESS (Same)		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslenio, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION CAUSING IT. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Penitonia DUE TO (B) Acute Pancreatitis DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH Hours Days		
19A. DATE OF OPERATION 12-3-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Penitonia		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12-3-65 19 to 12-9-65 19, that (I) (we) last saw the deceased alive on 12:25 am 12/9/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE C. A. CENDAÑA, M.D.					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 12-9-65	
23C. PHYSICIAN'S NAME (Type) C. A. CENDAÑA					23D. ADDRESS MERCY HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/11/65		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1965		25B. NAME OF REGISTRAR Robert E. Tolman		25C. FUNERAL DIRECTOR Leporello G. Buck Inc.		ADDRESS Balto. Md. 21214			

Archie
Archie

15-2-22 J. J. J. J. J.

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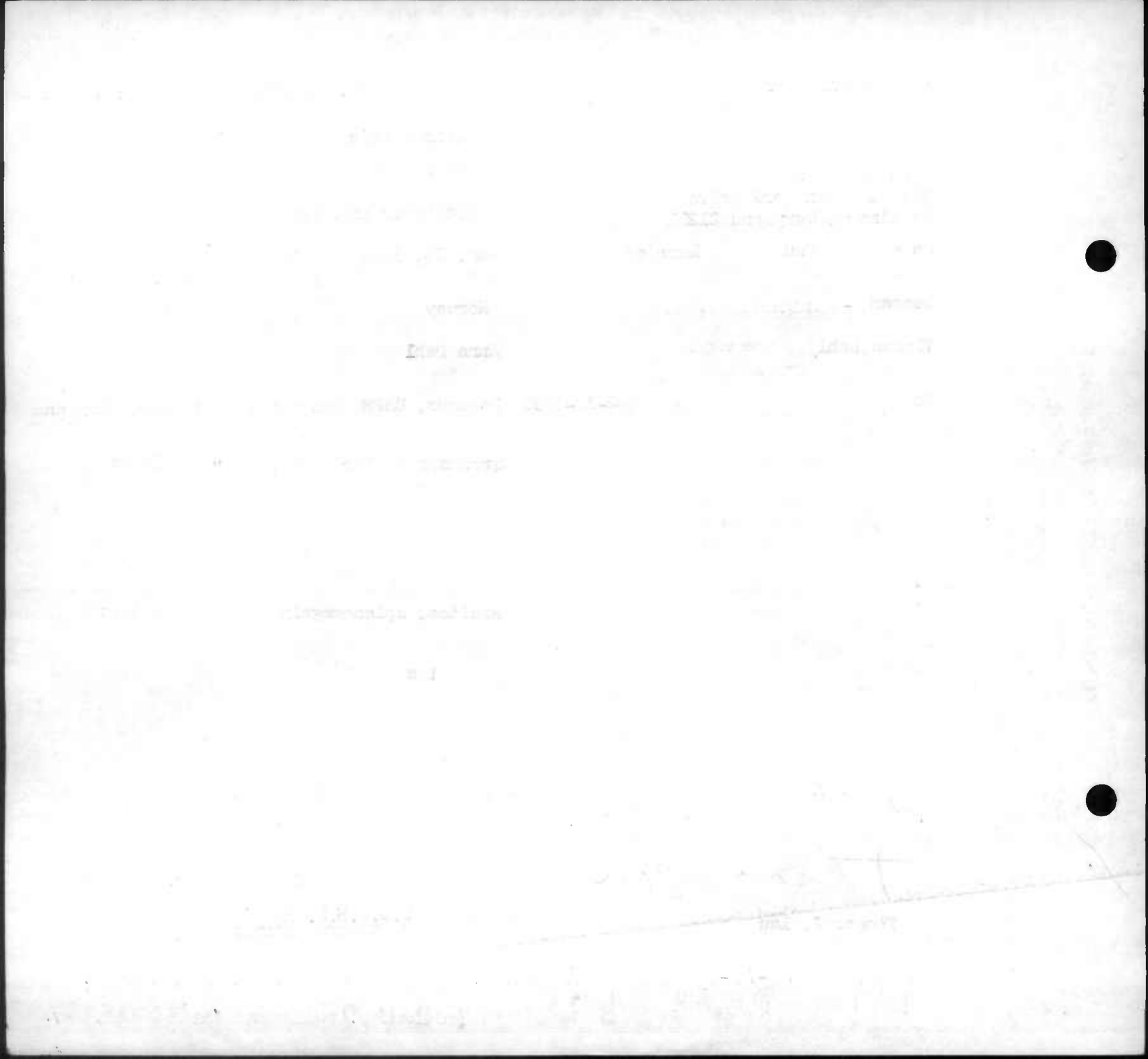
15-2-22

X

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12598	
BIRTH NO. 65 12598		CERTIFICATE OF DEATH			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) DAHL, Jens Simon		2. DATE AND HOUR OF DEATH Dec. 7, 1965 12:50 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION USPHS Hospital 31ST & Wyman Park Drive Baltimore, Maryland 21211		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pennsylvania B. COUNTY Phillipsburg C. CITY OR TOWN (If outside city limits, write RURAL and give township) Phillipsburg D. STREET ADDRESS (If rural, give location) Presbyterian Home			
5. SEX Male	6. RACE Cau	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Aug. 20, 1888	9. AGE (In years last birthday) 77	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman Merchant Marine		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Norway	
13. FATHER'S NAME Thomas (Dahl) Simonsen		14. MOTHER'S MAIDEN NAME Anna Dahl			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 092-12-1931		17. INFORMANT Records, USPHS Hospital, Baltimore, Maryland	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 58101 Cirrhosis of the liver, marked, Years		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Ascites, splenomegaly					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that X (this hospital) attended the deceased from Nov. 1 19 65 to Dec. 7 19 65 , that X (we) last saw the deceased alive on Dec. 7 19 65 and that in our (our) opinion death occurred on the date and hour and from the causes stated above. X (we) (did) XXXX view the body after death.					
23A. SIGNATURE Thomas J. Lau				23B. DATE SIGNED Dec. 7, 1965	
23C. PHYSICIAN'S NAME (Type) Thomas J. Lau		23D. ADDRESS U.S.P.H.S. Hospital Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 12-10-65		24C. NAME OF CEMETERY or CREMATORY Machpelah Cemetery	
24D. LOCATION (City, town, or county) (State) Union Township, Penna.		25A. DATE RECEIVED BY HEALTH DEPT. DEC 10 1965			
25B. NAME OF REGISTRAR Leonard J. Ruck		25C. FUNERAL DIRECTOR ADDRESS Inc Baltimore, Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12599		CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 12599	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CLIFTON PRESSER		2. DATE AND HOUR OF DEATH DEC. 10, 1965, 5:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSP.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 27-44 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5524 SEFTON AVE.			
5. SEX M	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH DEC. 29, '93	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY UNK.		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CLIFTON John Presser		14. MOTHER'S MAIDEN NAME EMMA Weisheit	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK.		16. SOCIAL SECURITY NO. UNK.		17. INFORMANT ADDRESS MR. CARL PRESSER - SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 381X I Cerebral hemorrhage massive		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Pulmonary edema, acute fat.		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21C. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21D. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21E. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from DEC. 9, 1965 to DEC. 10, 1965 , that we (we) last saw the deceased alive on DEC. 10, 1965 and that in our (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) did not view the body after death.					
23A. SIGNATURE L. Evan Custer		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED DEC. 10, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/13/65		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 10 1965			
25B. NAME OF REGISTRAR Robert J. Leonard		25C. FUNERAL DIRECTOR ADDRESS Leonard J. O'Ruck Inc 5305 Harford Rd.			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT

65 12601

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) JAMES A. WEBSTER				2. DATE AND HOUR PRONOUNCED DEAD 12/3/65 1:00 p.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 831 Eutaw St.				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 831 Eutaw St.			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH Aug 16, 1902	9. AGE (In years last birthday) 63	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN			14. MOTHER'S MAIDEN NAME UNKNOWN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS VA Administration Records, Balto., Md.				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH	
				(A) DUE TO			
				(B) DUE TO			
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/3/65							
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23B. DATE 12/10/65	23C. NAME of CEMETERY or CREMATORY BALTIMORE NATIONAL		23D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		
24A. DATE REC'D BY HEALTH DEPT. DEC 10 1965		24B. NAME OF REGISTRAR Robert E. Spitz		24C. FUNERAL DIRECTOR ADDRESS Robert E. Spitz Funeral Home Inc. 6009 HARFORD RD.			

VALLEY POLICE

INVESTIGATION

REPORT

100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12602	
BIRTH NO. 65 12602		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) DAVID SAMUEL MOORE JR		2. DATE AND HOUR OF DEATH Dec. 8 1965 6:25 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 15-11			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 3731 1/2 BELLEVUE AVE. BALTIMORE			
5. SEX MALE	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 12-22-35	9. AGE (In years last birthday) 29	10. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME David S. Moore Sr.		14. MOTHER'S MAIDEN NAME Martha Graham		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. 240-54-3500		17. INFORMANT MARY MOORE	
		ADDRESS Same		INTERVAL BETWEEN ONSET AND DEATH	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 744.01 Cordine failure shock system in Groin Pneumonia		(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov. 24, 1965 to Dec 8, 1965, that (I) (we) last saw the deceased alive on Dec 8, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Helen M. Bundary M.D.				23B. DATE SIGNED Dec. 8, 1965	
23C. PHYSICIAN'S NAME (Type) Helen M. Bundary M.D.				23D. ADDRESS UNIVERSITY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-12-65		24C. NAME OF CEMETERY OR CREMATORY Mt Pleasant Cmt	
24D. LOCATION North Carolina		25A. DATE REC'D BY HEALTH DEPT. DEC 10 1965			
25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Albus Funeral Home Inc.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No.	
65 12603						65 12603	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
DOROTHY JUANITA DUBOSE				12/7/65 5:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
UNIVERSITY HOSPITAL				MARYLAND, BALTIMORE			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				GLEN BURNIE 52-00			
				D. STREET ADDRESS (If rural, give location)			
				47 ORDINANCE ROAD			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
F	NEGRO	MARRIED	4-1-27	38			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE			—		MARYLAND		UNITED STATES
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOSEPH C. HOWARD				CAMPSIE PRICE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		—		PATIENT			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2		—		2		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from 12/7 1965 to 12/7 1965, that (1) (we) last saw the deceased alive on 12/7 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
RICHARD D. BIGGS JR.						12/7/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
RICHARD D. BIGGS JR.				UNIVERSITY HOSP. BALD			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)	
Burial		12-11-1965		Mt Calvary Cent		Brooklyn	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 10 1965		RICHARD D. BIGGS JR.		E. Wilson		1000 Brantley Dr	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BARBARA ANN WEILAND

2. DATE AND HOUR PRONOUNCED DEAD

12-5-65

4:55 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

CHURCH HOME & HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 21224

D. STREET ADDRESS (If rural, give location)

645 S. Decker Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

9-26-1889

9. AGE (In years
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

House Work

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Young

14. MOTHER'S MAIDEN NAME

Susan Klein

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-10-8073

17. INFORMANT

George J. Weiland

ADDRESS
912 Dorking Road
Same #12

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Pulmonary thrombo-embolus
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Phlebothrombosis, left leg
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

CHARLES S. PETTY

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-6-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-9-65

23C. NAME of CEMETERY or CREMATORY

Cedar Hill Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

DEC 13 1965

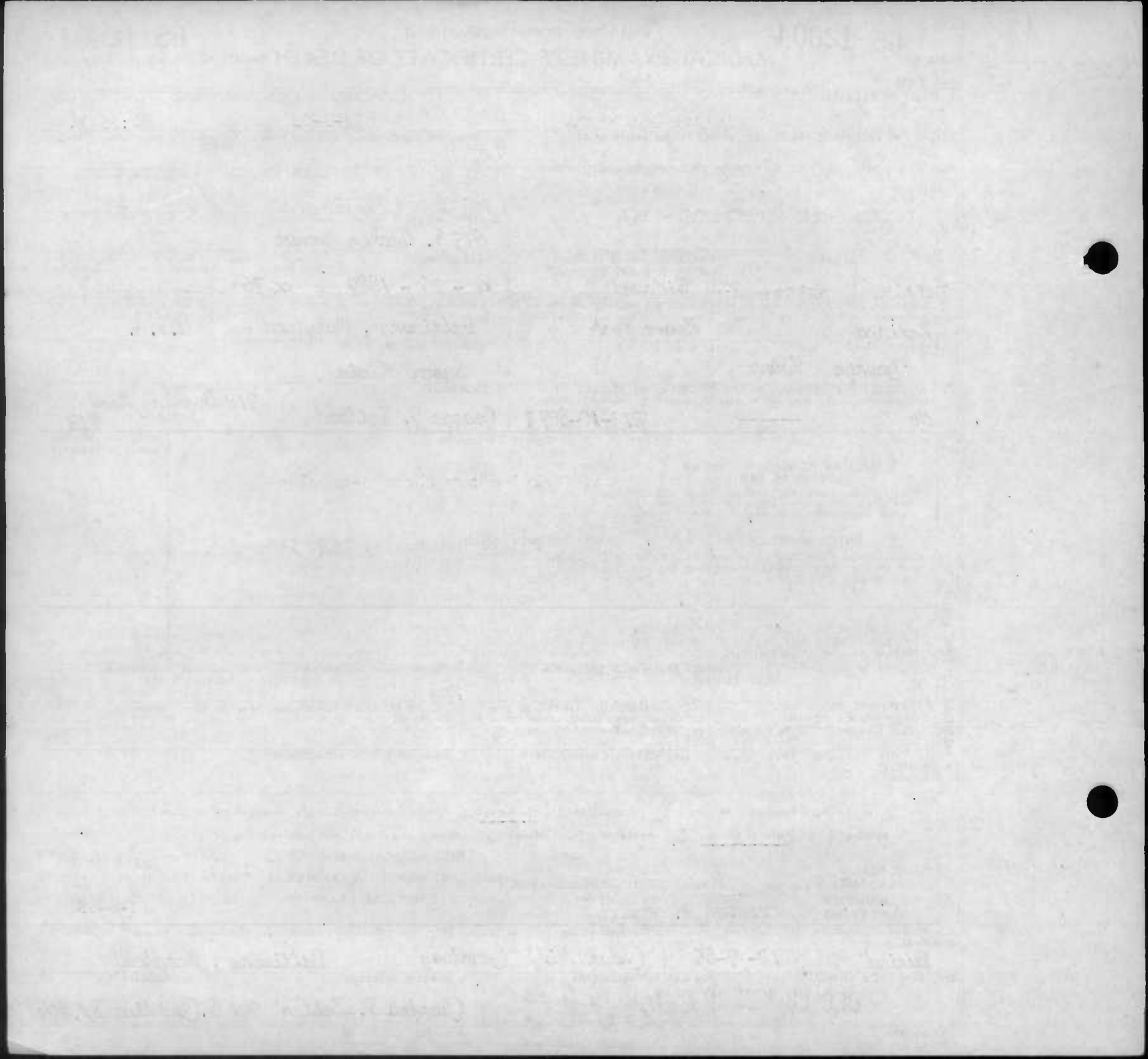
24B. NAME OF REGISTRAR

Robert E. [Signature]

24C. FUNERAL DIRECTOR

Charles S. Zeiler 901 S. Conkling St. #24

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 5		65 12605		65 12605	
M.E. CASE NO.		65 12605		65 12605	
1. NAME OF DECEASED (Type or Print)		LENTZ, FRANCIS M.		2. DATE AND HOUR OF DEATH 12-11-65 12:15A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE ZONE 29	
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL		D. STREET ADDRESS (If rural, give location) 4807 LINDSAY ROAD			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-16-93	9. AGE (In years lost birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Baltimore City		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME GEORGE LENTZ		14. MOTHER'S MAIDEN NAME MARY CULLEN		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219 20 8461		17. INFORMANT ST. AGNES RECORDS-CATON & WILKENS AVES	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) DUE TO Chemia (B) DUE TO CHF (C) GI Bleeding		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from DECEMBER 3 1965 to DECEMBER 11 1965, that (I) (we) last saw the deceased alive on DECEMBER 11 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Miguel Heredia</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-11-65	
23C. PHYSICIAN'S NAME (Type) MIGUEL HEREDIA		23D. ADDRESS ST. AGNES HOSP. CATON & WILKENS AVES. BALTO., MD. #29			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/14/65		24C. NAME OF CEMETERY or CREMATORY Woodlawn	
24D. LOCATION (City, town, or county) (State) Balto. 7, Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965			
25B. NAME OF REGISTRAR Witzke F.D.		25C. FUNERAL DIRECTOR 4101 Edmondson Ave.			

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FUNERAL DIRECTOR: IMPORTANT

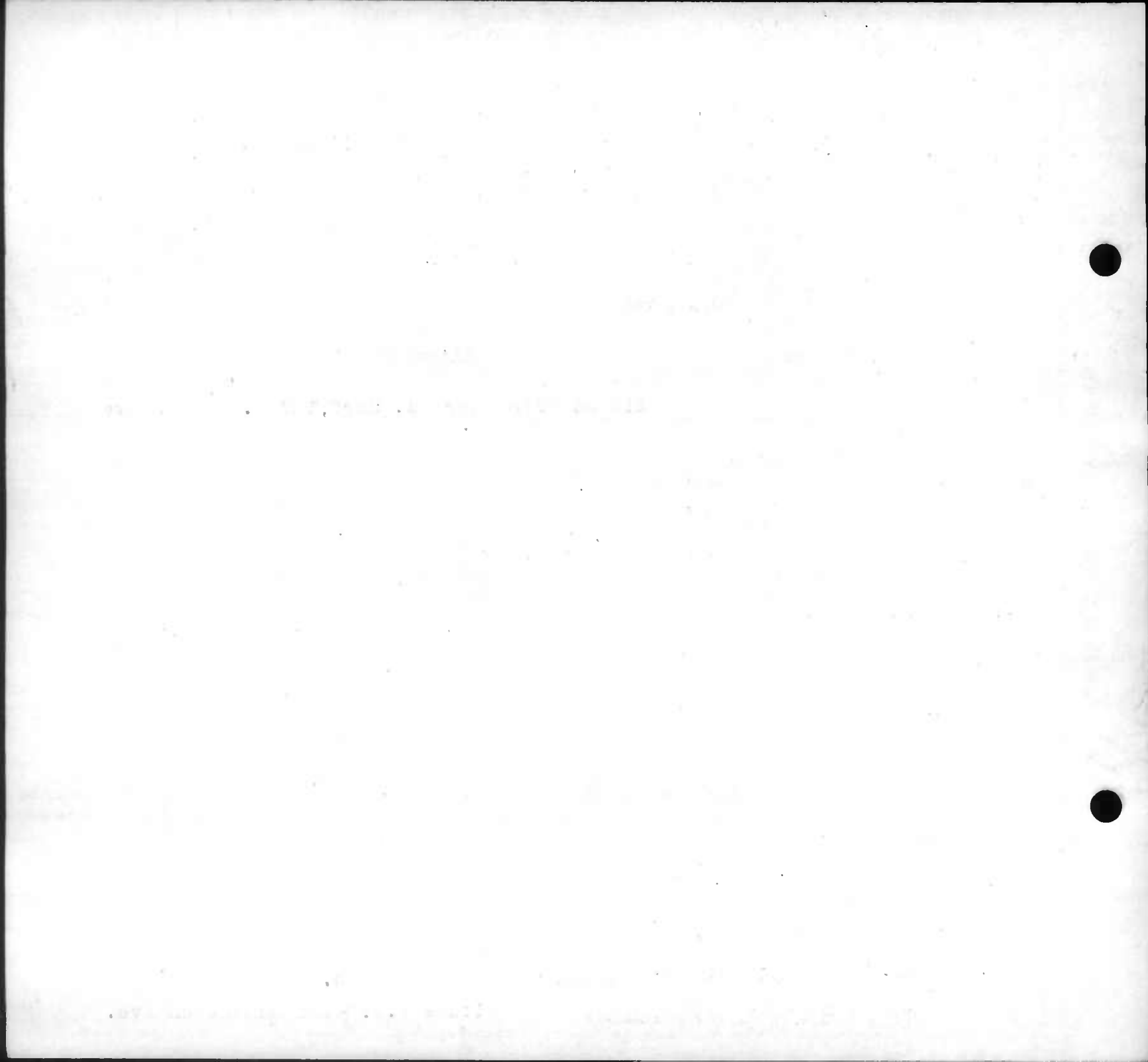
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 12606	
BIRTH NO. 65 12606		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) PHIPPS, CHARLES Spencer		2. DATE AND HOUR OF DEATH 11 DEC 65 10:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION U.S. Public Health Hosp.		(If not in hospital or institution, give street address or location)		A. STATE MD		B. COUNTY BALTO	
C. CITY OR TOWN BALTO		(If outside city limits, write RURAL and give township)		D. STREET ADDRESS 5007 Overton St		(If rural, give location)	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED Married	8. DATE OF BIRTH Dec. 20/95	9. AGE (In years last birthday) 69	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) MD.	
13. FATHER'S NAME late Harry C. Phipps				12. CITIZEN OF WHAT COUNTRY? USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 705 09 0003		17. INFORMANT ADDRESS Mrs. Selma Phipps, 5007 Overton St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Abnecarcinoma of the stomach with metastases to local lymph nodes, liver, and pancreas + ascites (4000) Months				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH years	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Recurrent arthritis			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Thomas L. Lall				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) THOMAS LALL	
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS Witzke F.D. 4101 Edmondson Ave	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 12/14/65		24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR Witzke F.D.		25C. FUNERAL DIRECTOR ADDRESS 4101 Edmondson Ave			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 65 12607					CERTIFICATE OF DEATH			Registered No. 65 12607		
1. NAME OF DECEASED (Type or Print) MARGARET HOPF					2. DATE AND HOUR OF DEATH 12/10/65 11:15 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 127 S. FULTON AVE.					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 7-23-03	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) GERMANY			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jacob Nicklass					14. MOTHER'S MAIDEN NAME Elizabeth Wedel					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 216 36 7975		17. INFORMANT ADDRESS Carl C. Hopf, 127 S. Fulton Ave					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ? ACUTE MYOCARDIAL INFARCTION					INTERVAL BETWEEN ONSET AND DEATH 5 MIN.					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. GENERALIZED ARTERIOSCLEROSIS					INTERVAL BETWEEN ONSET AND DEATH 2 MOS.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CEREBRAL ATROPHY - UNKNOWN ETIOLOG.					INTERVAL BETWEEN ONSET AND DEATH ? 2 MOS.					
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from NOV. 22 1965 to DEC. 10 1965 , that (I) (we) lost saw the deceased alive on DEC. 10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE M.A. Dennis					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 12/10/65.		
23C. PHYSICIAN'S NAME (Type) Margaret A. Dennis					23D. ADDRESS The Johns Hopkins Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 12/13/65		24C. NAME OF CEMETERY or CREMATORY Loudon Park			24D. LOCATION (City, town, or county) (State) Balto. Md			
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965			25B. NAME OF REGISTRAR Robert E. Williams			25C. FUNERAL DIRECTOR Witzke F.D.			ADDRESS 4101 Edmondson Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

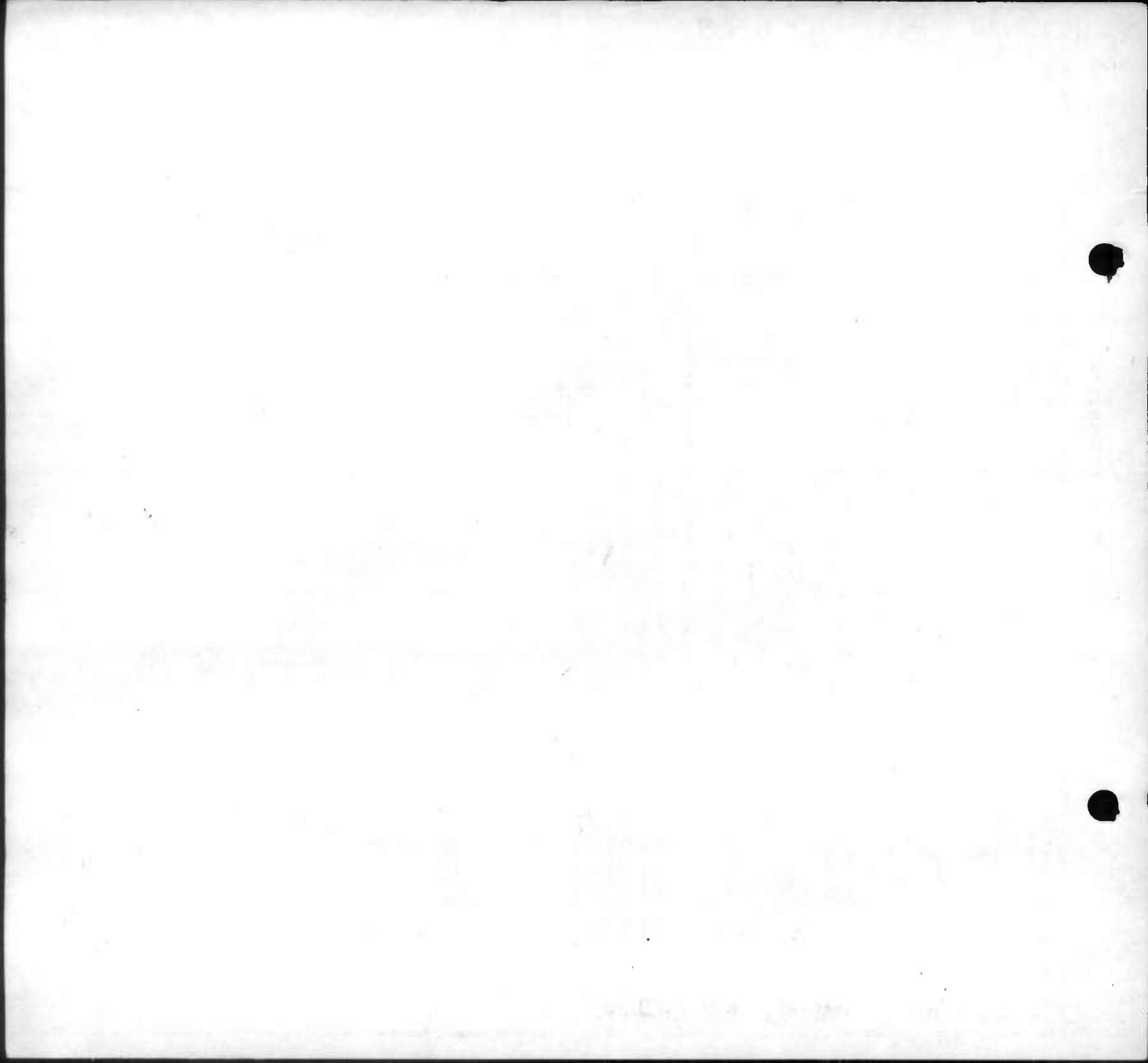
BALTIMORE CITY HEALTH DEPARTMENT				65 12608	
CERTIFICATE OF DEATH				Registered No. 65 12608	
BIRTH NO. <u>4</u>		65 12608			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) DISE, EWEEL EMERSON (Jack Dise)			2. DATE AND HOUR OF DEATH December 10, 1965 11:50 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
D. STREET ADDRESS (If rural, give location) 2636 Lauretta Avenue					
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9-12-96	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10B. KIND OF BUSINESS OR INDUSTRY Burns Detective Agcy.		11. BIRTHPLACE (State or foreign country) Tangier, Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME John T. Dise			14. MOTHER'S MAIDEN NAME Betty Spence		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 4/28/17 To 8/19/19		16. SOCIAL SECURITY NO. 215 07 4190		17. INFORMANT Records ADDRESS V. A. Hospital, Baltimore, Md. 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) severe Arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH Many years		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Malignant nephrosclerosis			2 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus			25 years		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 2, 1965 to December 10, 1965 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 10, 1965 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Anna R. Berk</i>				23B. DATE SIGNED 12-11-65	
23C. PHYSICIAN'S NAME (Type) Anna R. Berk				23D. ADDRESS M.D. V. A. Hospital, Baltimore, Maryland 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 12/14/65		24C. NAME OF CEMETERY or CREMATORY Balto. National	
				24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR R. E. F. F. F.		25C. FUNERAL DIRECTOR ADDRESS Witzke F.D. 4101 Edmondson Ave	

(10/1 2014)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

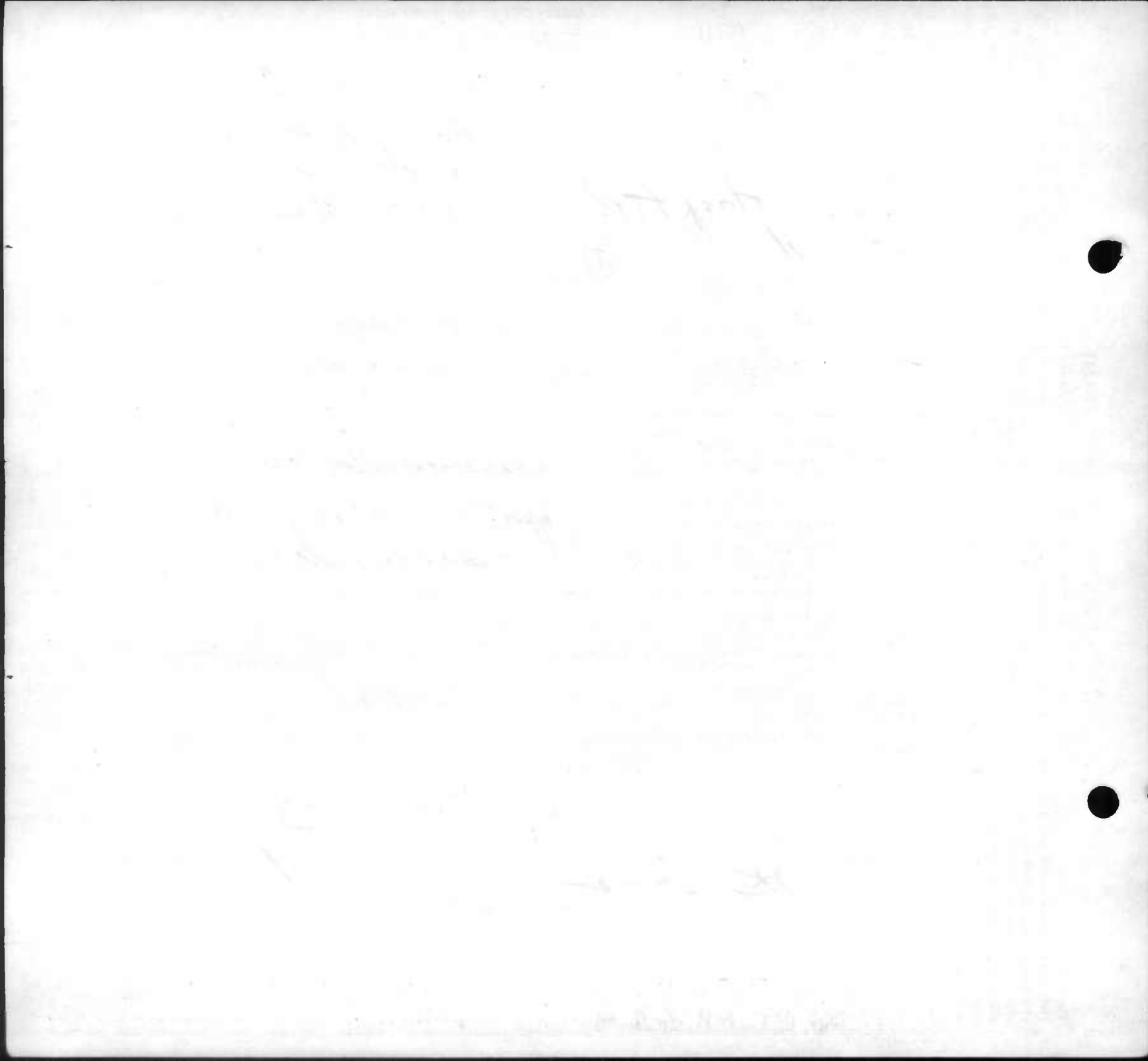
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12609	
65 12609				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		Charles W. Blunt		Dec 10, 1965	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
St Agnes Hospital		Md. Balto			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore			
D. STREET ADDRESS (If rural, give location)		2212 Hammonds Ferry Rd			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Male	W	Married	Apr 27, 1894	71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
			Balto Md		U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
Henry Blunt		Unknown		No	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
		Family		Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		Sudden	
ANTECEDENT CAUSES		(B) DUE TO		2 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
		Coronary Thrombosis			
		Hypertensive Cardia			
		Vascular Disease			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8:30 to 12:10 1965, that (I) (we) last saw the deceased alive on 12/4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. My associate					
23A. SIGNATURE				23B. DATE SIGNED	
Eliot W Johnson				12/11/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Eliot W Johnson MD.				3437 Sinden Rd Balto Md 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12/4/65		Meadowridge Cem	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 13 1965		R. E. Johnson		McCurley 237 Paterson Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

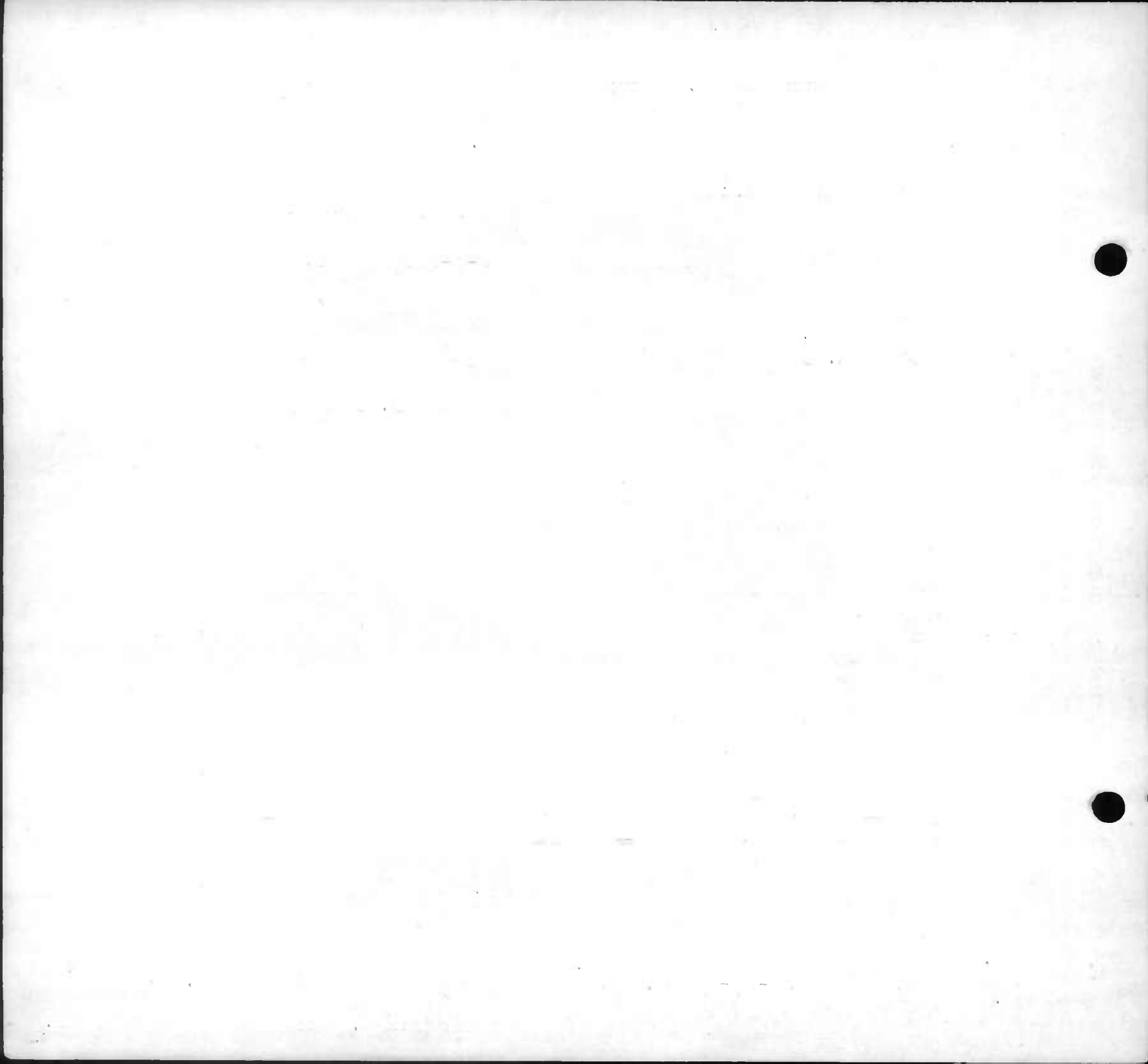
BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 12610					CERTIFICATE OF DEATH					Registered No. 65 12610				
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) <i>Gorsuch, Margaret R.</i>					2. DATE AND HOUR OF DEATH <i>12/10/65 8:40 A.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Baltimore</i>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				
FULL NAME OF HOSPITAL OR INSTITUTION <i>Simi Hosp Aal</i>					D. STREET ADDRESS (If rural, give location) <i>4012 Maine Ave</i>									
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>widowed</i>		8. DATE OF BIRTH <i>6/5/1933</i>		9. AGE (In years last birthday) <i>42</i>		10. If Under 1 Yr. Months: Days: Hours: Min.		11. If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					13. FATHER'S NAME <i>Frank X. Hermann</i>					14. MOTHER'S MAIDEN NAME <i>Susan Higdon</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT <i>John Wickham 8722 Silver Spring, Md. St. Apt 324</i>				
18. <i>443X I</i>					DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					19. ANTECEDENT CAUSES					20. INTERVAL BETWEEN ONSET AND DEATH				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>12/10/65</i> to <i>12/10/65</i> , that (I) (we) last saw the deceased alive on <i>12/10/65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										23A. SIGNATURE <i>[Signature]</i> M.D.				
23B. DATE SIGNED <i>12/10/65</i>					23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>					24B. DATE <i>12-13-65</i>					24C. NAME of CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>				
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>					25A. DATE REC'D BY HEALTH DEPT. <i>DEC 13 1965</i>					25B. NAME OF REGISTRAR <i>[Signature]</i>				
25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc</i>					25D. ADDRESS <i>Baltimore, Md.</i>									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12611	
BIRTH NO. 65 12611		CERTIFICATE OF DEATH			
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) Ann E. Frey		
2. DATE AND HOUR OF DEATH 12/11/65 1:30 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Gould Convalesarium			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 1331 Stonewood Road		
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) single	8. DATE OF BIRTH 1-9-1884	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at Home			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Louis H. Frey			14. MOTHER'S MAIDEN NAME Elizabeth Deschinger		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO.		17. INFORMANT Louis F. Frey
					ADDRESS same
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Anterior wall myocardial infarction			CAUSE OF DEATH (A) DUE TO Anterior wall myocardial infarction (B) DUE TO dissecting (C)		INTERVAL BETWEEN ONSET AND DEATH 10 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the physician) attended the deceased from January 1963 to December 1965 , that (I) (we) lost saw the deceased alive on December 19, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.					
23A. SIGNATURE A. Allan Sines				23B. DATE SIGNED 12/11/65	
23C. PHYSICIAN'S NAME (Type) A. Allan Sines				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 12-14-65		24C. NAME OF CEMETERY or CREMATORY Mt. Carmel Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR Robert E. Sines		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12612	
BIRTH NO. 65 12612		CERTIFICATE OF DEATH		65 12612	
1. NAME OF DECEASED (Type or Print) HOWARD L. DAVIES		2. DATE AND HOUR OF DEATH 12/9/65 10 26 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSP.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3702 FAIRVIEW AVE 21226 MD. 15-38			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 12-30-03	9. AGE (In years last birthday) 61	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SOCIAL SECURITY ADMINISTRATION		10B. KIND OF BUSINESS OR INDUSTRY OHIO		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME DAVID T. DAVIES (Dec)		14. MOTHER'S MAIDEN NAME ESTELLA LONGFELLOW (Dec)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 3		16. SOCIAL SECURITY NO. 114-12-1184		17. INFORMANT ADDRESS SELF from adm. slip.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Partial Pneumothorax Right Co Pulmonale Emphysema		CAUSE OF DEATH Partial Pneumothorax Right Co Pulmonale Emphysema		INTERVAL BETWEEN ONSET AND DEATH Recent 5 years? 20 years	
19A. DATE OF OPERATION 12/9/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Right Pneumothorax treated with closed thoracotomy		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/8/65 19 65 to 12/9/65 19 65 , that (I) (we) last saw the deceased alive on 12/9/65 19 65 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James E. Hopkins		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/9/65	
23C. PHYSICIAN'S NAME (Type) JAMES E. T. HOPKINS		23D. ADDRESS 205 W. Lombard 21217			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/13/65		24C. NAME OF CEMETERY OR CREMATORY Goodlawn	
24D. LOCATION (City, town, or county) Goodlawn Md		(State)			
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR R. E. F. Jones		25C. FUNERAL DIRECTOR ADDRESS Harry A. Amacest 4204 Redwood Lane	

DAVID L. DAVIS

3709 Tenth Avenue

Washington, D.C.

MARKLAND GENEALOGICAL

M. DAVIS 18-30-03

SOCIAL SECURITY ADMINISTRATION

DAVID T. DAVIS (D.C.)

Self from name

M.E. CASE NO.

VS 151-REV. 1/1/65

WALLEY & CO

W. A. Waller

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. 65 12614					
BIRTH NO. 65 12614										
M.E. CASE NO.										
1. NAME OF DECEASED (Type or Print) <i>Bernard Edward Blair</i>					2. DATE AND HOUR OF DEATH <i>7:00 PM 12-8-65</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Balto.</i>					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>U.H. University Hosp.</i>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTO.</i>					
					D. STREET ADDRESS (If rural, give location) <i>7488 German Hill Rd.</i>					
5. SEX <i>M.</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>M</i>	8. DATE OF BIRTH <i>8/16/20</i>	9. AGE (In years last birthday) <i>45</i>	If Under 1 Yr. Months: Days: Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Interior Decorator</i>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>John J. Blair</i>					14. MOTHER'S MAIDEN NAME <i>Frederica Decker</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes. 1943-1945</i>			16. SOCIAL SECURITY NO. <i>212-12-6131</i>		17. INFORMANT ADDRESS <i>Son (Same as above)</i>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>ARTERIOSCLEROTIC HEART DISEASE, Acute Anterior MI</i>					INTERVAL BETWEEN ONSET AND DEATH					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO <i>Supraventricular Ectopic Tachy.</i>					
					(C) DUE TO <i>Cardiac Insult - Pulm. Edema</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <i>12/8/65</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (this hospital) attended the deceased from <i>12/8/65</i> 19 to <i>12/8/65</i> 1965, that (we) last saw the deceased alive on <i>12/8/65</i> 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.										
23A. SIGNATURE <i>E. Ann Robinson</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <i>12/8/65</i>		
23C. PHYSICIAN'S NAME (Type) <i>E. Ann Robinson MD</i>					23D. ADDRESS <i>500 Mace Ave. Balto. 21</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>12/13/65</i>			24C. NAME OF CEMETERY OR CREMATORY <i>Balto. National</i>			24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 13 1965</i>			25B. NAME OF REGISTRAR <i>Robert E. F...</i>			25C. FUNERAL DIRECTOR <i>Connolly</i>				

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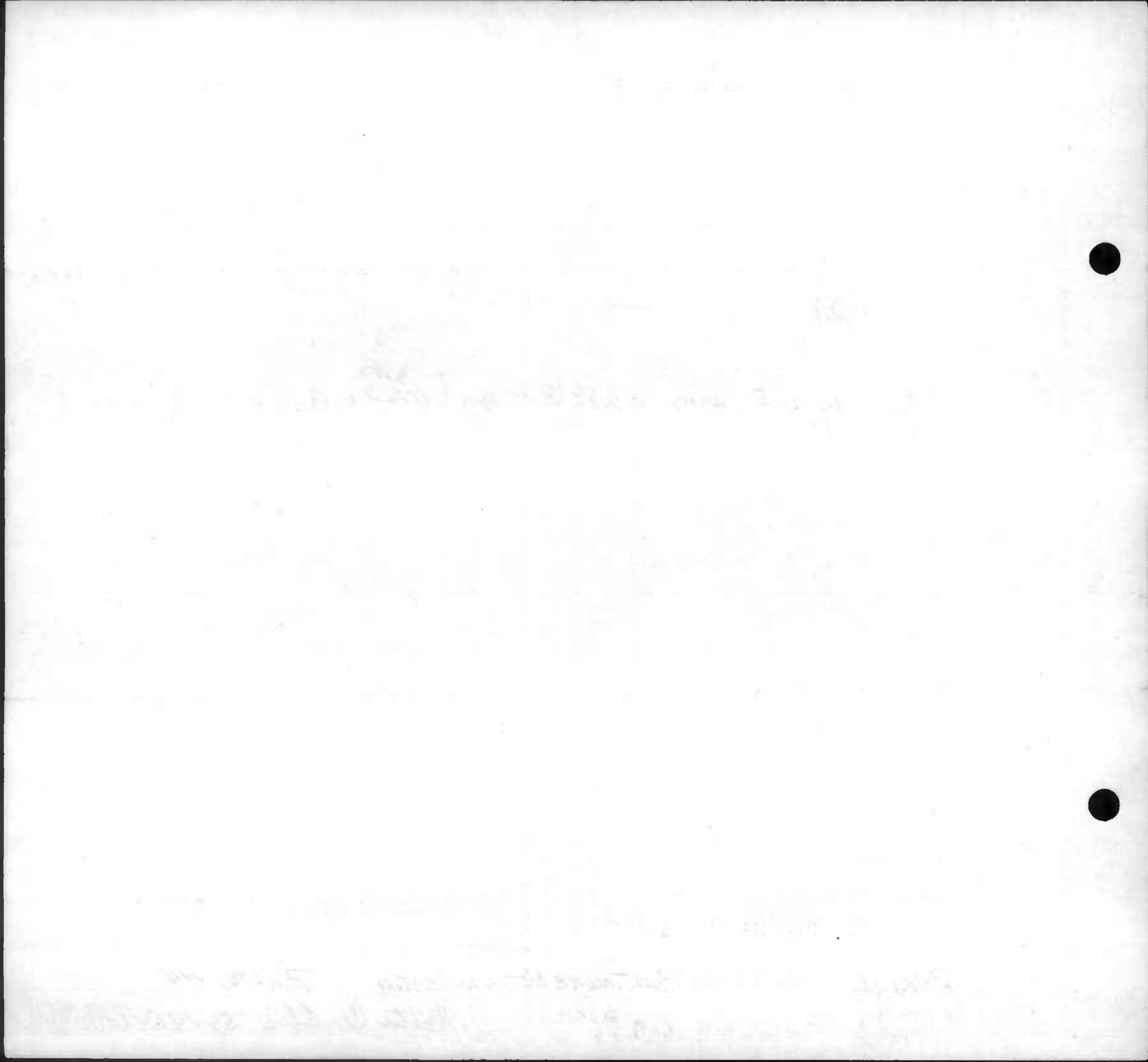
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

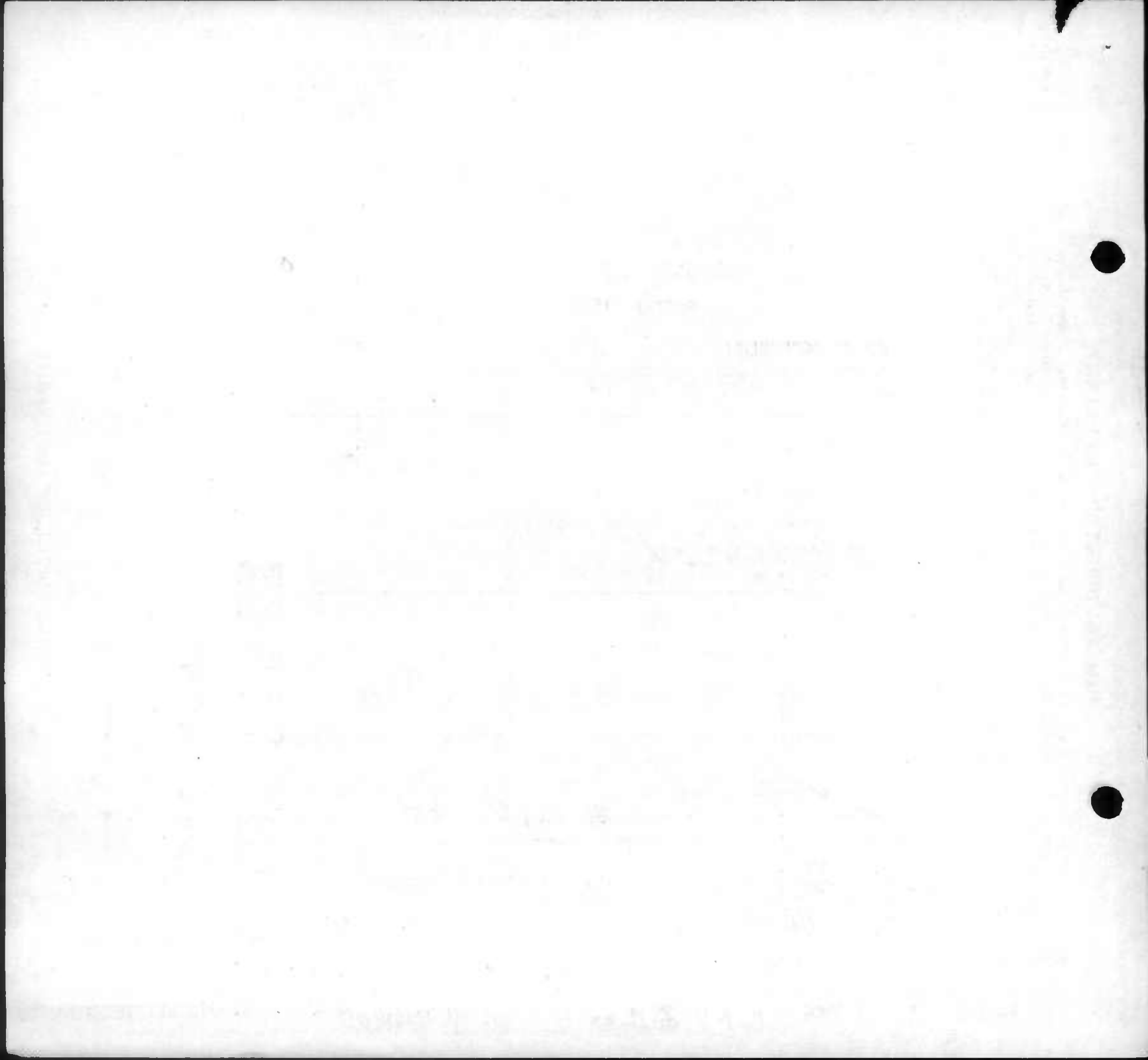
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 12615	
BIRTH NO. 65 12615		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BOUCHET, ANTHONY F.		2. DATE AND HOUR OF DEATH 1965 . 12 . 8 - 65 6 . 15 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION The Union Memorial Hospital		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 12-06	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 2507 N. Charles Street			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married		8. DATE OF BIRTH 12/18 199	9. AGE (In years last birthday) 65	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA AMERICA	
13. FATHER'S NAME SAMUEL BOUCHET				14. MOTHER'S MAIDEN NAME JULIA, A. SULLIVAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.I. ARMY		16. SOCIAL SECURITY NO. 219-16-4646		17. INFORMANT WIFE MRS. LILLIAN C. BOUCHET		ADDRESS (SAME)	
18. 133.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Massive Gastro-intestinal hemorrhage DUE TO 2° to a chronic peptic ulcer. (B) cirrhosis of the liver, with DUE TO a localized hepatoma. (C) fract		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/16 19 65 to 12/8 19 65 , that (I) (we) last saw the deceased alive on 6:15 PM 12-8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Pyong Il Kwon				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-8 '65	
23C. PHYSICIAN'S NAME (Type) DR. PYONG IL KWON				23D. ADDRESS The Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-13-1965		24C. NAME OF CEMETERY BALTIMORE NATIONAL CEMETERY		24D. LOCATION (City, town, or county) (State) BALTO, MD	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR J. Walter Conklin		25C. FUNERAL DIRECTOR J. Walter Conklin		ADDRESS 5444 BELAIR RD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

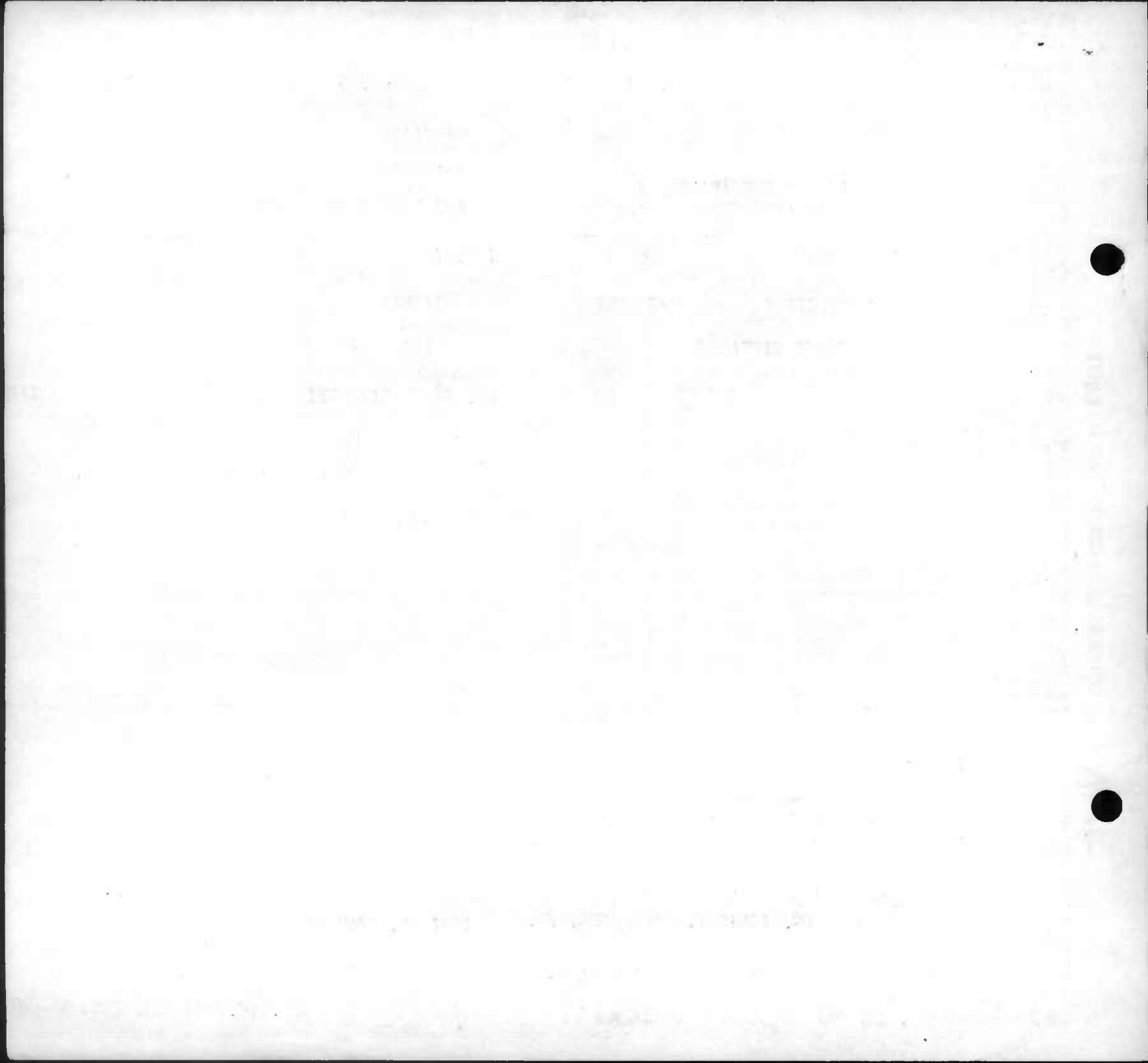
BALTIMORE CITY HEALTH DEPARTMENT																			
65 12616					Certificate of Death					Registered No. 65 12616									
BIRTH NO. 65 12616					M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) Frank Rosenblum					2. DATE AND HOUR OF DEATH December 9, 1965 6:35 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE md. B. COUNTY 13-01					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					D. STREET ADDRESS (If rural, give location) 2413 Lakeview Ave				
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital					5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married					8. DATE OF BIRTH 12/5/1889 9. AGE (In years last birthday) 76					10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired					10B. KIND OF BUSINESS OR INDUSTRY POSTAL CLERK					11. BIRTHPLACE (State or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME SIMON ROSENBLUM					14. MOTHER'S MAIDEN NAME RACHEL ROSENBERG					15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. NO				
17. INFORMANT Chant					ADDRESS														
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Renal Failure & Respiratory Failure										INTERVAL BETWEEN ONSET AND DEATH 4 days									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral Vascular Accident										25 days									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION 11-20-65					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Femoral Vein Occlusion					20A. AUTOPSY? (Yes or No) No					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that the (this hospital) attended the deceased from 11/14 19 65 to 12/9 19 65 , that (I) (we) last saw the deceased alive on 12/8 19 65 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE Donald T. Lewers MD					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 12/9/65									
23C. PHYSICIAN'S NAME (Type) Donald T. Lewers					23D. ADDRESS Maryland General Hosp														
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL					24B. DATE 12/10/65					24C. NAME OF CEMETERY or CREMATORY HEBREW FRIENDSHIP					24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND				
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965					25B. NAME OF REGISTRAR P. E. E. Johnson					25C. FUNERAL DIRECTOR SQL LEVINSON					ADDRESS BROS. INC. 6010 REISTERSTOWN RD				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12617		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 12617	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HENRIETTA G. BLAUSTEIN		2. DATE AND HOUR OF DEATH DECEMBER 8, 1965 10:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LAKE DRIVE APARTMENTS 903 LAKE DRIVE APT 6A		6. STREET ADDRESS (If rural, give location) 903 LAKE DRIVE APT 6A			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 1/22/1870	9. AGE (In years (last birthday) 95	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) LATVIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JACOB GITTLESON		14. MOTHER'S MAIDEN NAME IDA ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT MR. JACOB BLAUSTEIN ALTO DALE FARM PIKESVILLE	
18. 450.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) Congestive heart failure (B) Atherosclerosis (C)		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1952 to Dec 8, 1965, that (I) (we) last saw the deceased alive on Dec 6, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE DR. LOUIS P. HAMBURGER, JR.		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/8/65	
23C. PHYSICIAN'S NAME (Type) DR. LOUIS P. HAMBURGER, JR.		23D. ADDRESS 1001 ST. PAUL STREET			
24A. BURIAL CREMATION, REMOVAL (Specify) ENTOMBMENT		24B. DATE 12/10/65		24C. NAME OF CEMETERY or CREMATORY OHEB SHALOM	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR R. E. F. J. J.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 12618

BIRTH NO.

65 12618

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

(WALL) Wohl, Belle #.

2. DATE AND HOUR OF DEATH

12-10-65 1050 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

SINAI HOSP OF BALTIMORE, INC.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland, Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore #15

D. STREET ADDRESS (If rural, give location)

4009 Rosecrest Ave

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

3/5/1895

9. AGE (In years last birthday)

70

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

ABRAHAM ZOLMAN, Rosen berg

14. MOTHER'S MAIDEN NAME

unknown SHANA ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

unknown

17. INFORMANT

ADDRESS

Harry M. Walen 5356 Carriage Cr. 21229

18.

720.11

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) acute myocardial infarction Immediate

(B) ASCVD over 10 Years

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

None Known

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

None

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

none

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-3-1965 to 12-10-1965, that (I) (we) last saw the deceased alive on 12-10-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Harry M. Walen

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

12-10-65

23C. PHYSICIAN'S NAME (Type)

HARRY M. WALEN

23D. ADDRESS

M.D. 5356 Carriage Court, Baltimore 21229

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

12/12/65

24C. NAME of CEMETERY or CREMATORY

BETH JACOB (VECAIR)

24D. LOCATION

(City, town, or county)

(State)

ROSEDALE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

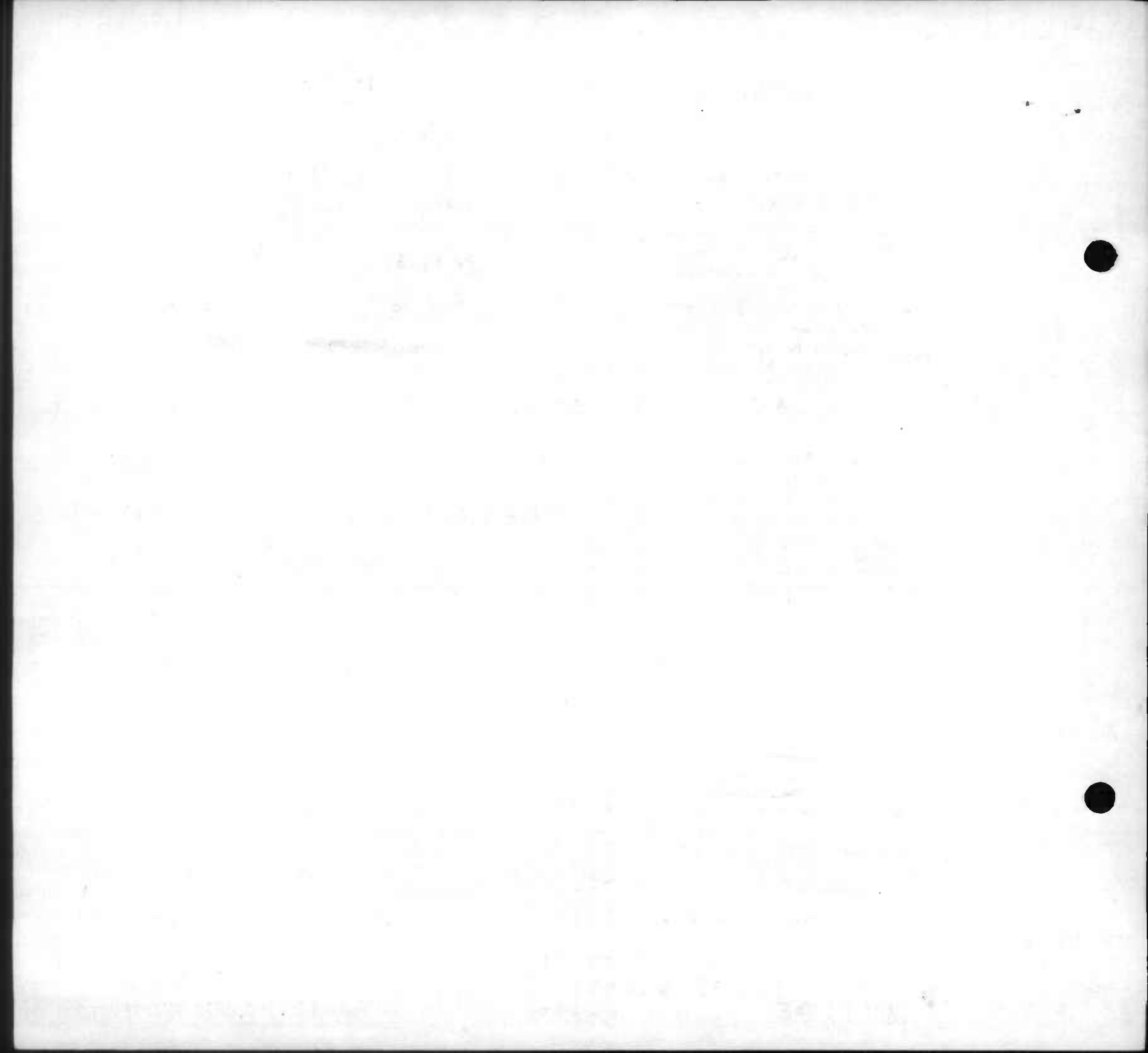
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25B. NAME of FUNERAL HOME

965001

25C. FUNERAL DIRECTOR

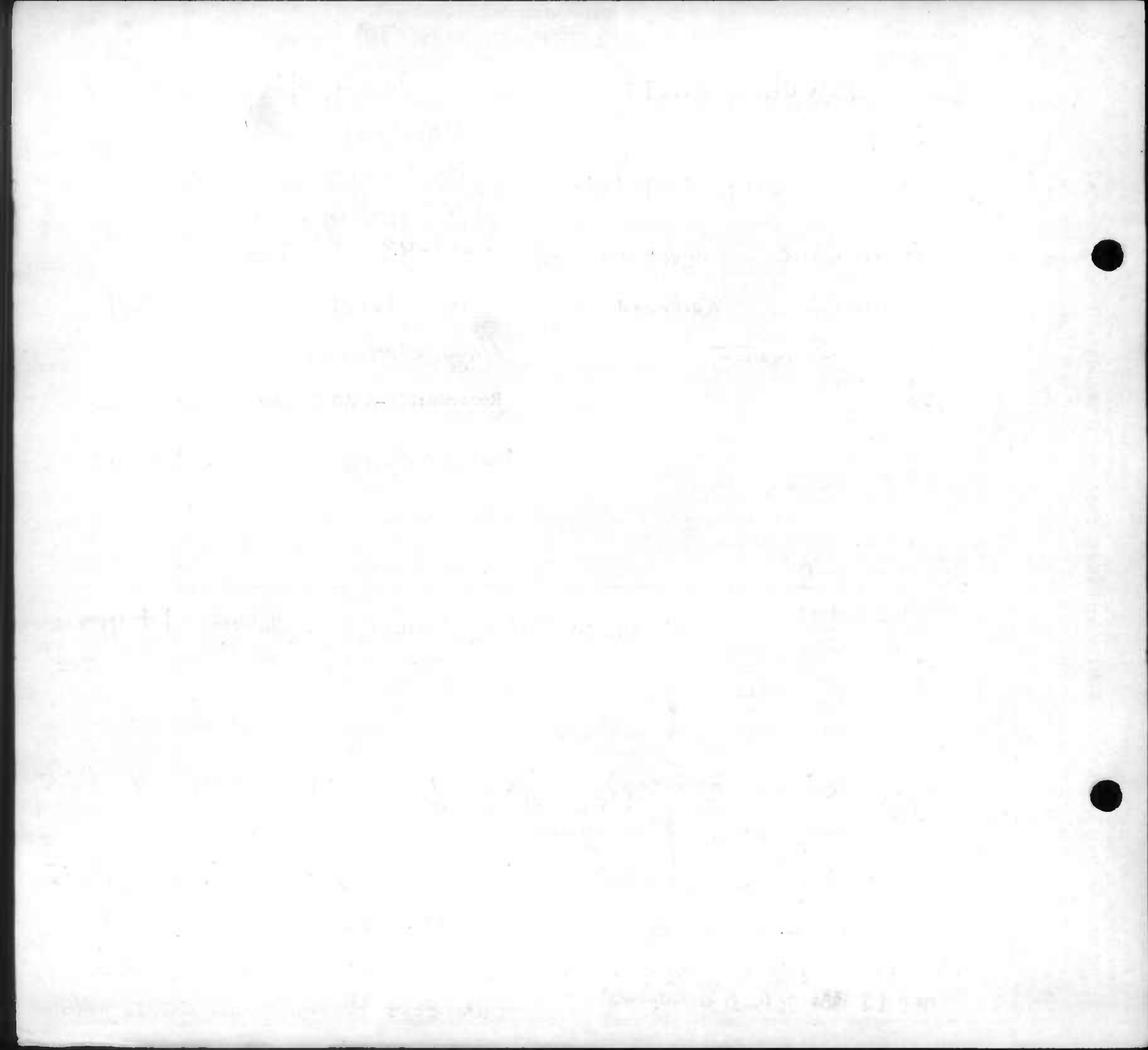
SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD



FUNERAL DIRECTOR: IMPORTANT

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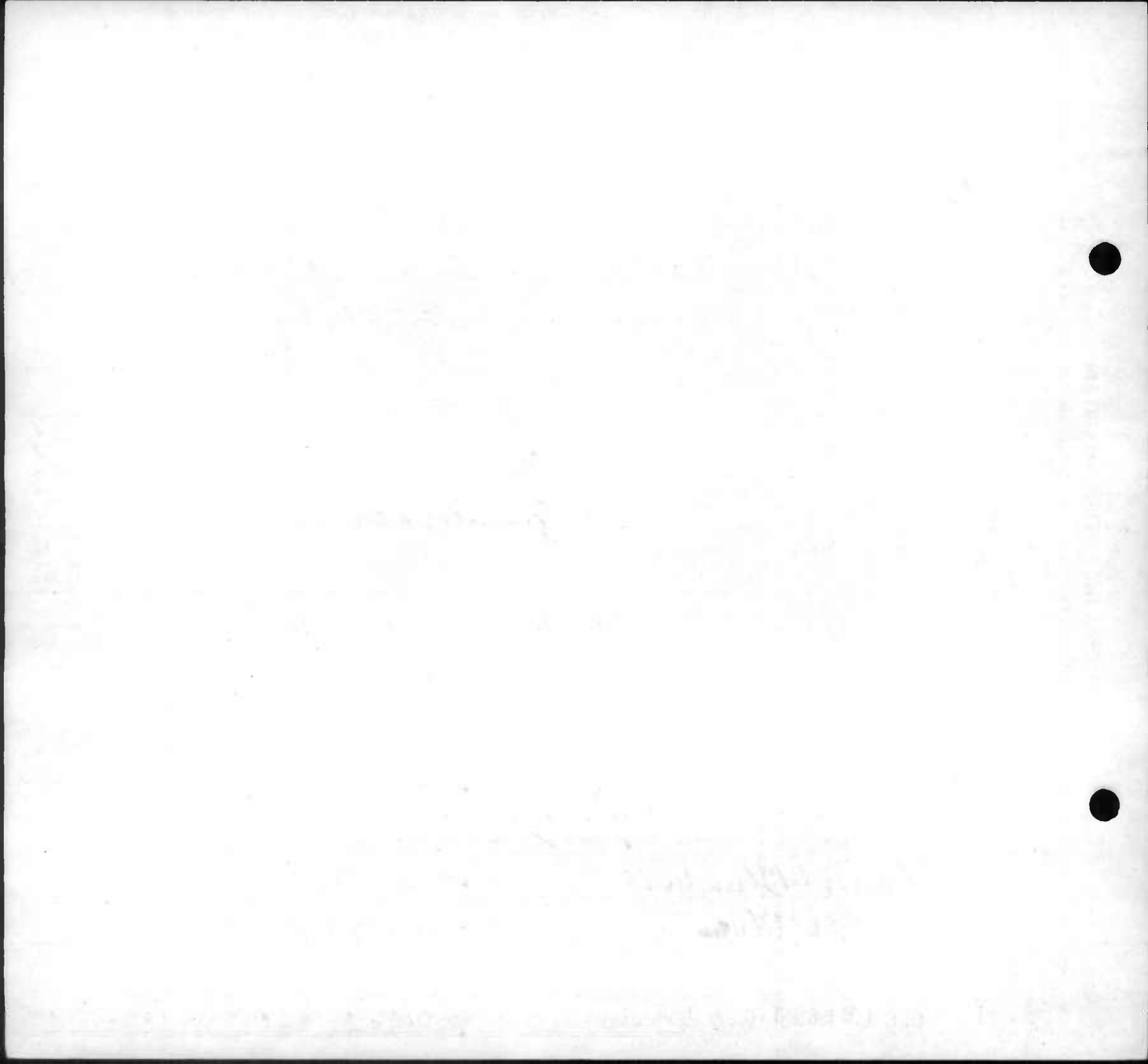
BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH						Registered No.					
BIRTH NO. 65 12619						65 12619					
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) Joseph Sinnott						2. DATE AND HOUR OF DEATH Dec 4, 1965 5³⁸ P M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals						A. STATE Maryland B. COUNTY 19-04					
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					
						D. STREET ADDRESS (If rural, give location) 1700 Hollins St					
5. SEX Male		6. RACE Cauc.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) never married		8. DATE OF BIRTH 7-17-93		9. AGE (In years last birthday) 72		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10B. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sinnott						14. MOTHER'S MAIDEN NAME Maggie Murphy					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224					
<div style="display: flex; justify-content: space-between;"> <div> <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div> <p>CAUSE OF DEATH</p> <p>(A) pneumonia</p> <p>(B) 24 hrs</p> <p>(C) 1 + yrs</p> </div> </div>											
						<p>19. DATE OF OPERATION 2</p> <p>20A. AUTOPSY? (Yes or No) Yes</p> <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes</p>					
						<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p> <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p> <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> <p>21F. HOW DID INJURY OCCUR?</p>					
<p>22. I certify that (1) (this hospital) attended the deceased from Dec 1 19 65 to Dec 4 19 65. that (1) (we) last saw the deceased alive on Dec 4 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</p>											
23A. SIGNATURE Alan E. Oestreich						23B. DATE SIGNED Dec. 4, 1965					
23C. PHYSICIAN'S NAME (Type) Alan E. Oestreich						23D. ADDRESS Baltimore City Hospitals					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12/10/65		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem.				24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965				25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Walters Funeral Home - Balto., Md.				ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

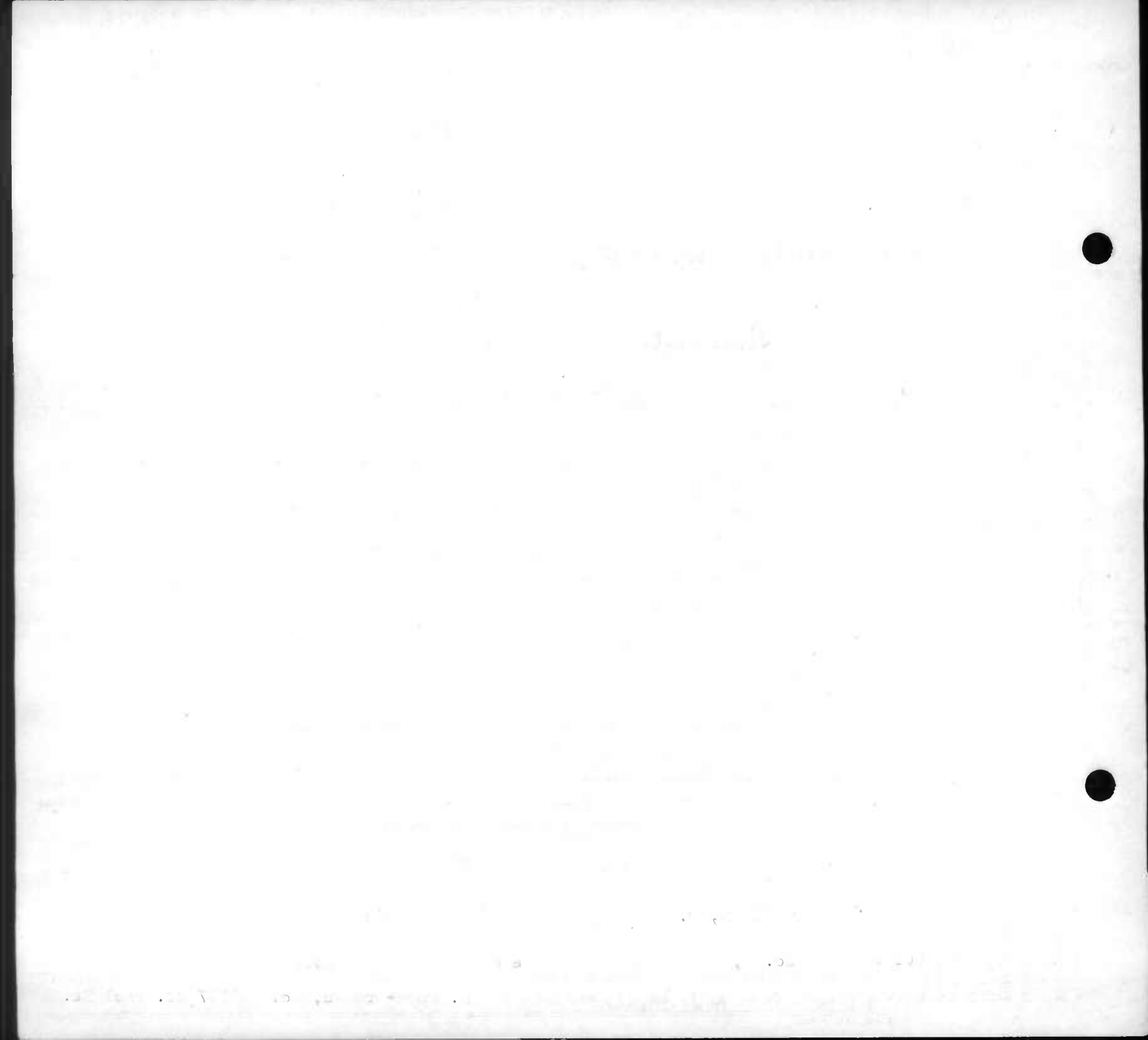
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12620	
BIRTH NO. 65 12620		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Cordie W. Morgan		2. DATE AND HOUR OF DEATH Dec 8, 1965 11 ⁰⁰ a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2504			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Park Hill Nursing Home		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 500 Pontiac ave			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 11-10-85	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kentucky	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME James O. Woford		14. MOTHER'S MAIDEN NAME Rebecca Woford			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	17. INFORMANT Family Some ADDRESS		
18. 334X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Chronic Brain Disease DUE TO (B) Generalized Art sclerosis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH sev. years years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute respiratory infection				per days	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/9 1963 to 12/8 1965, that (I) (we) last saw the deceased alive on Dec 6 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Louis V. Blum		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/8/65	
23C. PHYSICIAN'S NAME (Type) Louis V. Blum		23D. ADDRESS M.D. 3502 W. Rogers An Balt 9, Ind			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-11-65		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cem	
				24D. LOCATION (City, town, or county) (State) Balto 25 Ind	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR R. E. Feltner		25C. FUNERAL DIRECTOR McCallister H. 237 Patapsco Ave	
				ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

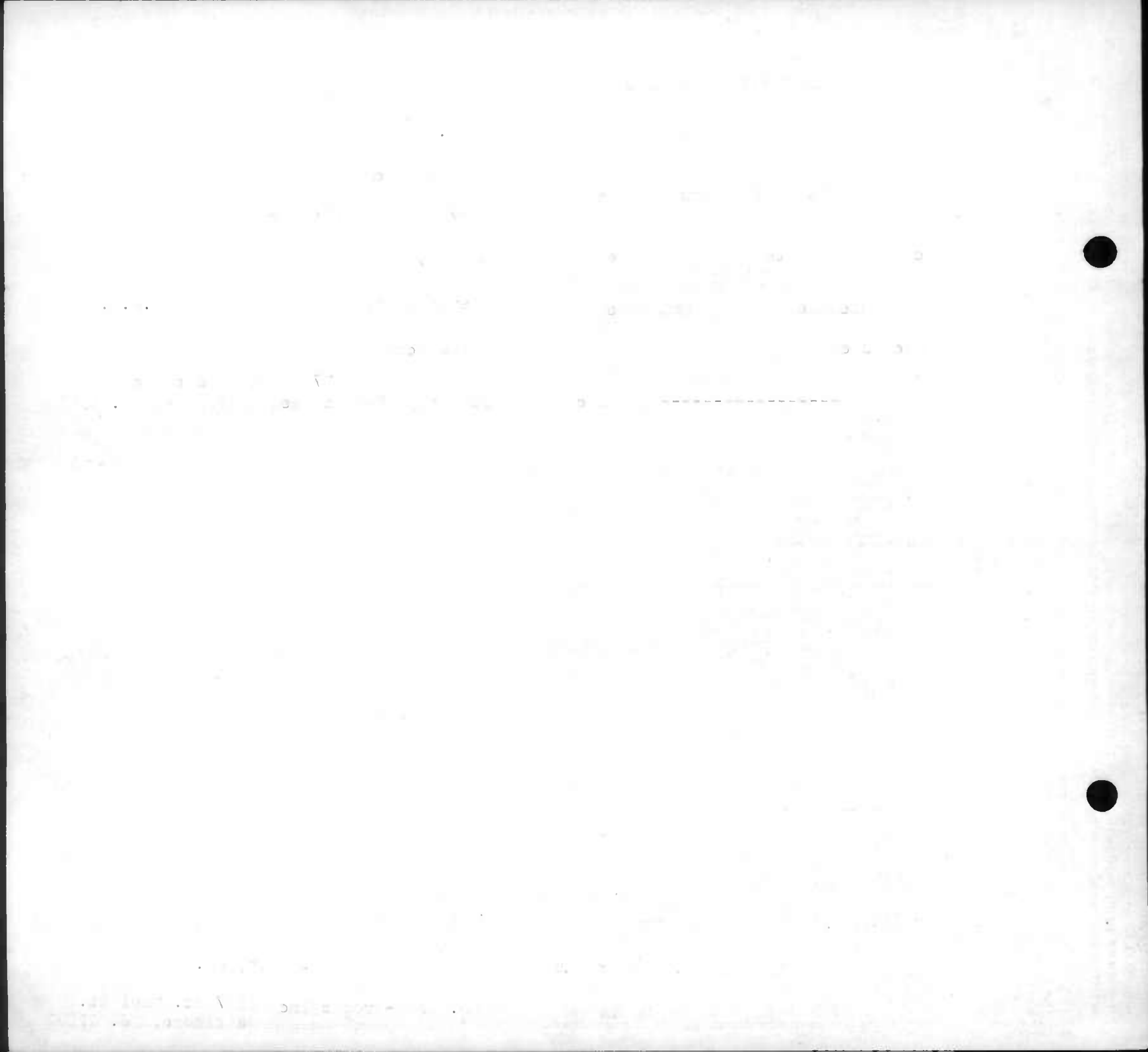
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 12621		CERTIFICATE OF DEATH		65 12621	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		White, MRS. LELIA L.		12-9-65 7 P.m. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION KESWICK		A. STATE MARYLAND		B. COUNTY 13-07	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN BALTIMORE		(If outside city limits, write RURAL and give township)	
		D. STREET ADDRESS 700 W. 40th STREET		(If rural, give location)	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widow	8. DATE OF BIRTH 6-9-1873	9. AGE (In years last birthday) 92	10. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Samuel Leonard		14. MOTHER'S MAIDEN NAME ROSA COOPER		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-52-2464		17. INFORMANT KESWICK Home Records - Dr. Beckford R.W.	
18. 334 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Bronchopneumonia DUE TO (B) Chronic bronchitis, severe DUE TO (C) Cerebral arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 48 hrs. years	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 12-9-1965, that (I) (we) last saw the deceased alive on 12-9-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. Hunter Wilson, Jr.				23B. DATE SIGNED 12-10-65	
23C. PHYSICIAN'S NAME (Type) E. Hunter Wilson, Jr.				23D. ADDRESS % The Keswick Home	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 11, 1965		24C. NAME OF CEMETERY or CREMATORY Spring Hill Cemetery	
24D. LOCATION Easton		24E. LOCATION Maryland		24F. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR P. A. P. Talbot		25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc. 1217 St. Paul St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

65 12622		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12622	
CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
LENA DEWS		DEC 8 1965		3:15 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Bolton Hill Nursing Home		A. STATE Md.		B. COUNTY 15-38	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
		D. STREET ADDRESS (If rural, give location)		3714 Springdale Ave	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
Female	White	Widowed	July 15, 1881	84	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Own Home		Newnan, Georgia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Joe Askew		Ida Scroggin			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		None		3714 Springdale Ave Mrs Evelyn Van De Veer Baltimore, Md. 21216	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Arteriosclerotic heart disease		4 years	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nally medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from Dec 2 1965 to Dec 8 1965, that (I) (we) last saw the deceased alive on Nov 26 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
ABRAHAM B. HURWITZ				DEC 9 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
ABRAHAM B. HURWITZ		7501 LIBERTY ROAD BALTIMORE MD			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12/10/65		Lorraine Park	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 13 1965		R. H. E. F. 0 2 1		Wm. Cook-Brooks Inc 1217 St. Paul St. Baltimore, Md. 21202	



BIRTH NO.

65 12623

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 12623

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

RALPH W. CAMPBELL

2. DATE AND HOUR PRONOUNCED DEAD

December 8, 1965

8:35 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

207 E. Preston St.,

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

Mar. 4, 1915

9. AGE (In years
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Painter

10B. KIND OF BUSINESS OR INDUSTRY

Contracting

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Robert L. Campbell

14. MOTHER'S MAIDEN NAME

Rosie Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Lewis Campbell 1418 Virginia Ave.
Front Royal, Va.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Fatty metamorphosis of liver
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in at about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-8-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-12-1965

23C. NAME OF CEMETERY or CREMATORY

Willis Chapel

23D. LOCATION

(City, town, or county)

Huntly,

(State)

Va.

24A. DATE REC'D BY HEALTH DEPT.

DEC 13 1965

24B. NAME OF REGISTRAR

R. C. A. P. Sullivan

24C. FUNERAL DIRECTOR

G. Howard Strong 3207 W. North Ave.,

ADDRESS

WALLLEY FORD

BY TOWN

[Signature]

THIS CASE HAS BEEN RELEASED ON APPROVAL BY DR. PETTY
OF THE MEDICAL EXAMINER'S OFFICE
FUNERAL DIRECTOR: IMPORTANT DIRECTIONS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12624		BALTIMORE CITY HEALTH DEPARTMENT REGISTERED NO. 65 12624	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Gunther-Joseph G.</i>		2. DATE AND HOUR OF DEATH <i>12-10-65 12:47 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE PENNSYLVANIA B. COUNTY <i>11-35</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) SPRINGFIELD D. STREET ADDRESS (If rural, give location) 439 THATCHER ROAD	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-18-11
9. AGE (In years last birthday) 54		10. If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Organ Company	
11. BIRTHPLACE (State or foreign country) Philadelphia, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Karol Gunther		14. MOTHER'S MAIDEN NAME Ludwika Norotarska	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Joseph T. Sekula		ADDRESS 2634 E. Allegheny Ave. Philadelphia, Penna.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Dissecting aortic aneurysm 1 day		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 3/12/10/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Dissecting aortic aneurysm	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/10/65 to 12/10/65 , that (I) last saw the deceased alive on 12/10 2:47 PM 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Jerry S. Dorman</i>		23B. DATE SIGNED 12/10/65	
23C. PHYSICIAN'S NAME (Type) JERRY S. DORMAN M.D.		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 12-11-65	
24C. NAME OF CEMETERY or CREMATORY Holy Sepulchre Cemetery		24D. LOCATION (City, town, or county) (State) Philadelphia, Penna.	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR <i>Robert E. F...</i>	
25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc.		ADDRESS 1217 St. Paul St.	

RECEIVED
JAN 10 1960
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

RECEIVED
JAN 10 1960
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12625	
BIRTH NO. 65 12625		CERTIFICATE OF DEATH		Registered No. 65 12625	
1. NAME OF DECEASED (Type or Print) EDWARD C. CRAIG			2. DATE AND HOUR OF DEATH Dec. 9, 1965 7:30p.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 239 E. Grindall St.			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 24-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 239 E. Grindall St.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3/18/99	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10B. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) Harrisburg, Pa.	
13. FATHER'S NAME Albert H. Craig			14. MOTHER'S MAIDEN NAME Isabelle Coleman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No --		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mrs. Betty Craig 239 E. Grindall St.		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) coronary occlusion DUE TO (B) hypertensive cardiac disease DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Apr 5 1965 to 12/9 1965 , that (I) (we) last saw the deceased alive on 12/9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Philip W. Keister M.D.			23B. DATE SIGNED 12/10/65		
23C. PHYSICIAN'S NAME (Type) Philip W. Keister M.D.			23D. ADDRESS 302 Patuxent Ave Baltimore		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/13/65		24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial	
24D. LOCATION Dorsey, Md.					
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR John F. Denny		25C. FUNERAL DIRECTOR ADDRESS JOHN F. DENNY, INC. 715 Light St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		65 12626		65 12626	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Florence Sherman			12-8-65 8:50p.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
35 Church Home & Hosp.			Md. 26-34		
5. SEX			6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
F			W		Married
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Mass	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Burgess			Cugas		
15. Was Deceased ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
					Chart
18. 442X + 162.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO Ventricular fibrillation ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE (B) DUE TO Coronary artery disease (C) HYPOPLASTIC LEFT KIDNEY due to ARTERIOSCLEROTIC LEFT RENAL ARTERY		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Oat cell Carcinoma, lung		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-8-65 to 12-8-65, that (I) (we) last saw the deceased alive on 12-8-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Dr. A. E. Subong Jr.			12-8-65		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Dr. A. E. Subong Jr.			Church Home & Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12-13-65		Woodlawn Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 13 1965		R. E. E. J. D. M.		John C. Miller Inc-6415 Belair Rd. 21206	

Handwritten notes at the top of the page, including the word "Hypnotic" and other illegible scribbles.

HYPERBOLIC LEFT KIDNEY
HYPERBOLIC LEFT KIDNEY
HYPERBOLIC LEFT KIDNEY

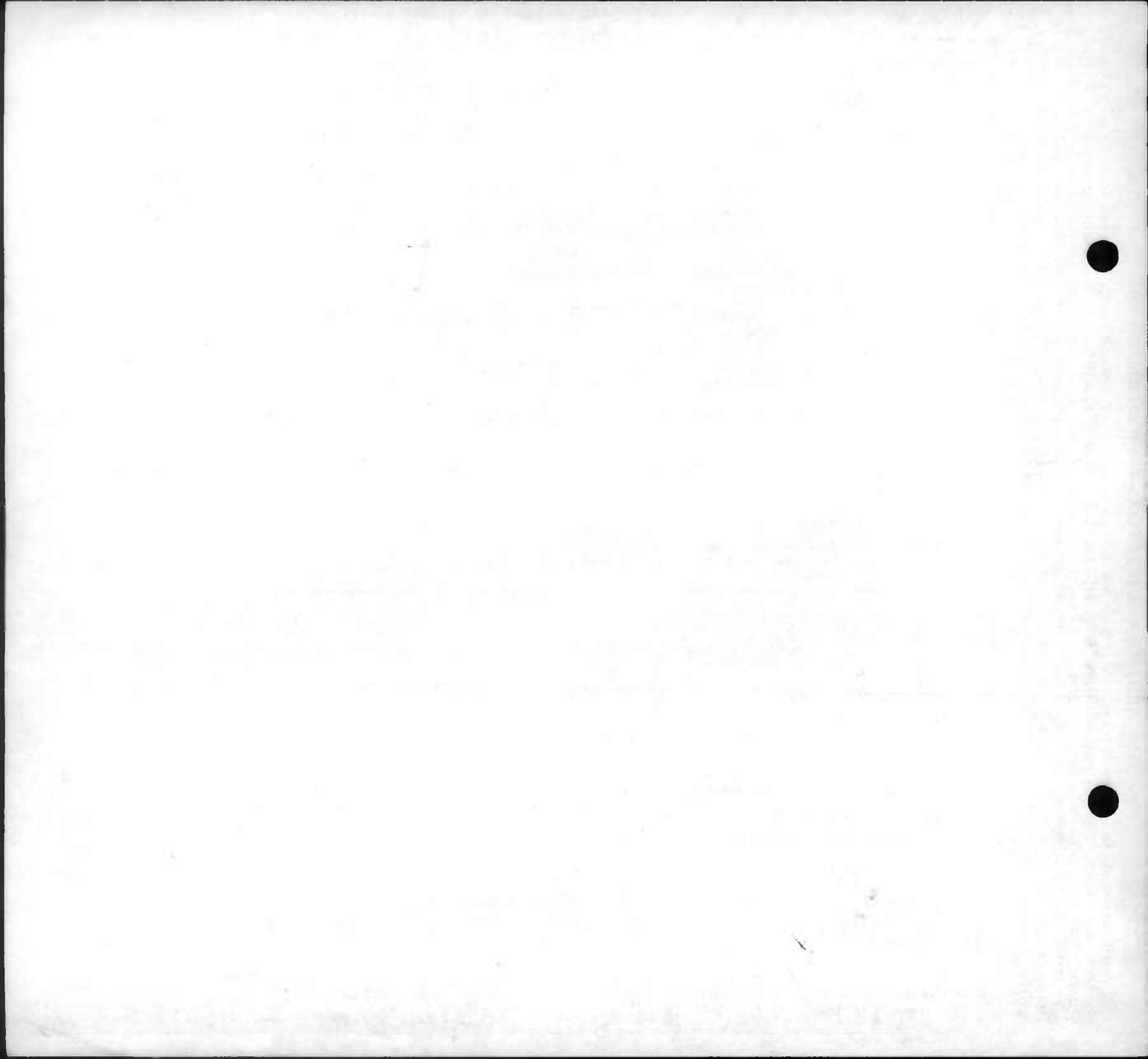
Handwritten notes at the bottom of the page, including the word "Hypnotic" and other illegible scribbles.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

Registered No. ~~65~~ 12627

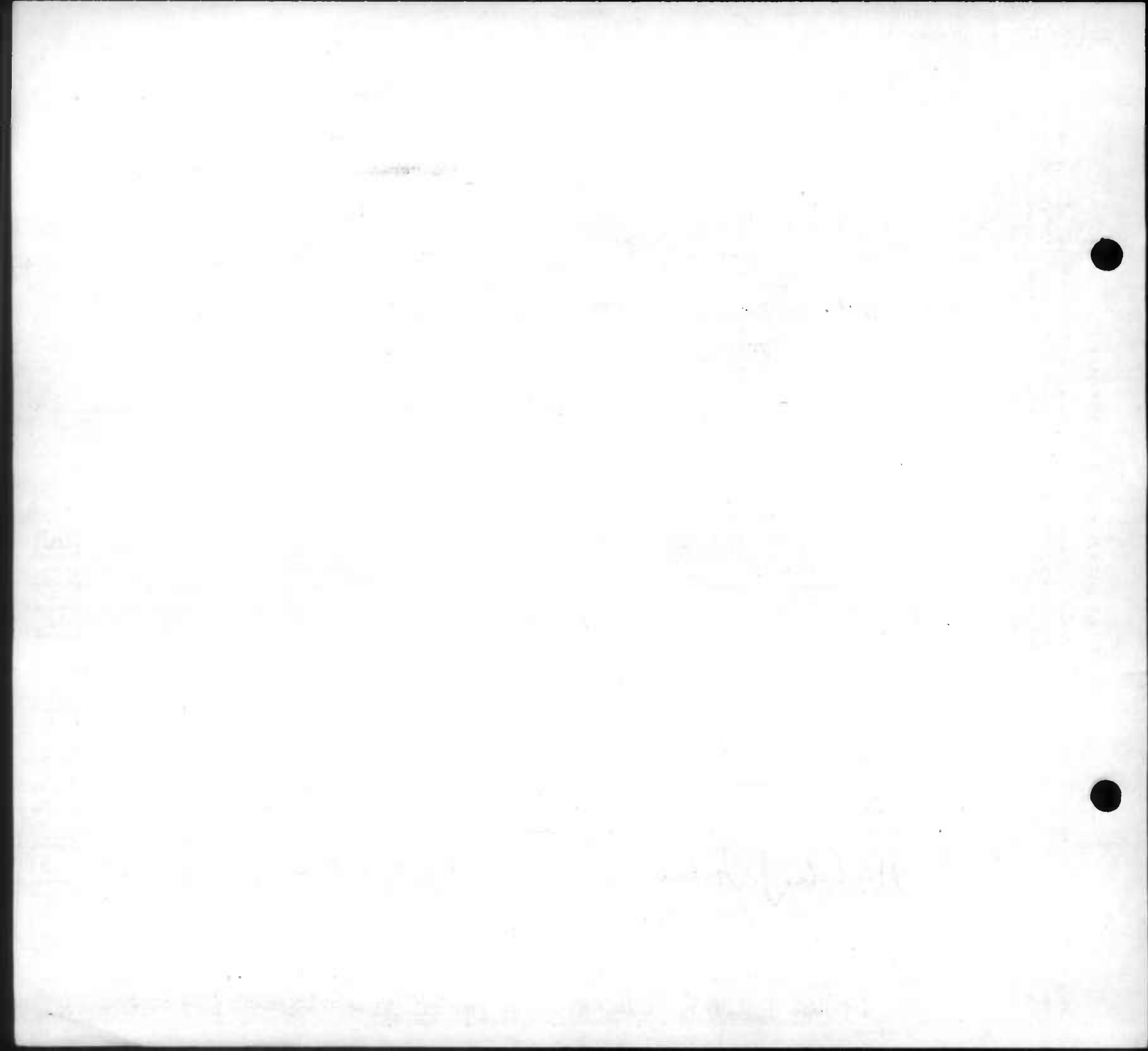
BIRTH NO. 65-30187				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12627	
M.E. CASE NO. 65 12627				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Baby Boy Powers (Robert John)</u>				2. DATE AND HOUR OF DEATH <u>12-9-65 1:37 AM</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <u>Balto.</u> B. COUNTY <u>Maryland.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Linnai Hospital of Balto. Inc.</u> <u>Belvedere and Greenspring Ave</u> <u>Baltimore 15, Maryland</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>26-03</u>			
D. STREET ADDRESS (If rural, give location) <u>Same as 3-3604 Edman Ave</u>							
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>12-3-65</u>	9. AGE (In years last birthday) <u>—</u>	If Under 1 Yr. Months: <u>96</u> Days: <u>—</u> Hours: <u>—</u> Min. <u>—</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Same as 3</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Powers</u>				14. MOTHER'S MAIDEN NAME <u>Patricia KRAMER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Medical Record</u> ADDRESS <u>SAME AS 3</u>			
18. <u>776 XI</u> CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Prematurity</u>							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (nately medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12-3-1965</u> to <u>12-9-1965</u> that (I) (we) last saw the deceased alive on <u>12-8-1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Stanley L Blum</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>12-9-65</u>			
23C. PHYSICIAN'S NAME (Type) <u>STANLEY L BLUM</u> M.D.				23D. ADDRESS <u>SAME AS (3)</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/10/65</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>John C. Haller Inc - 6415 Belair Rd.</u> ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

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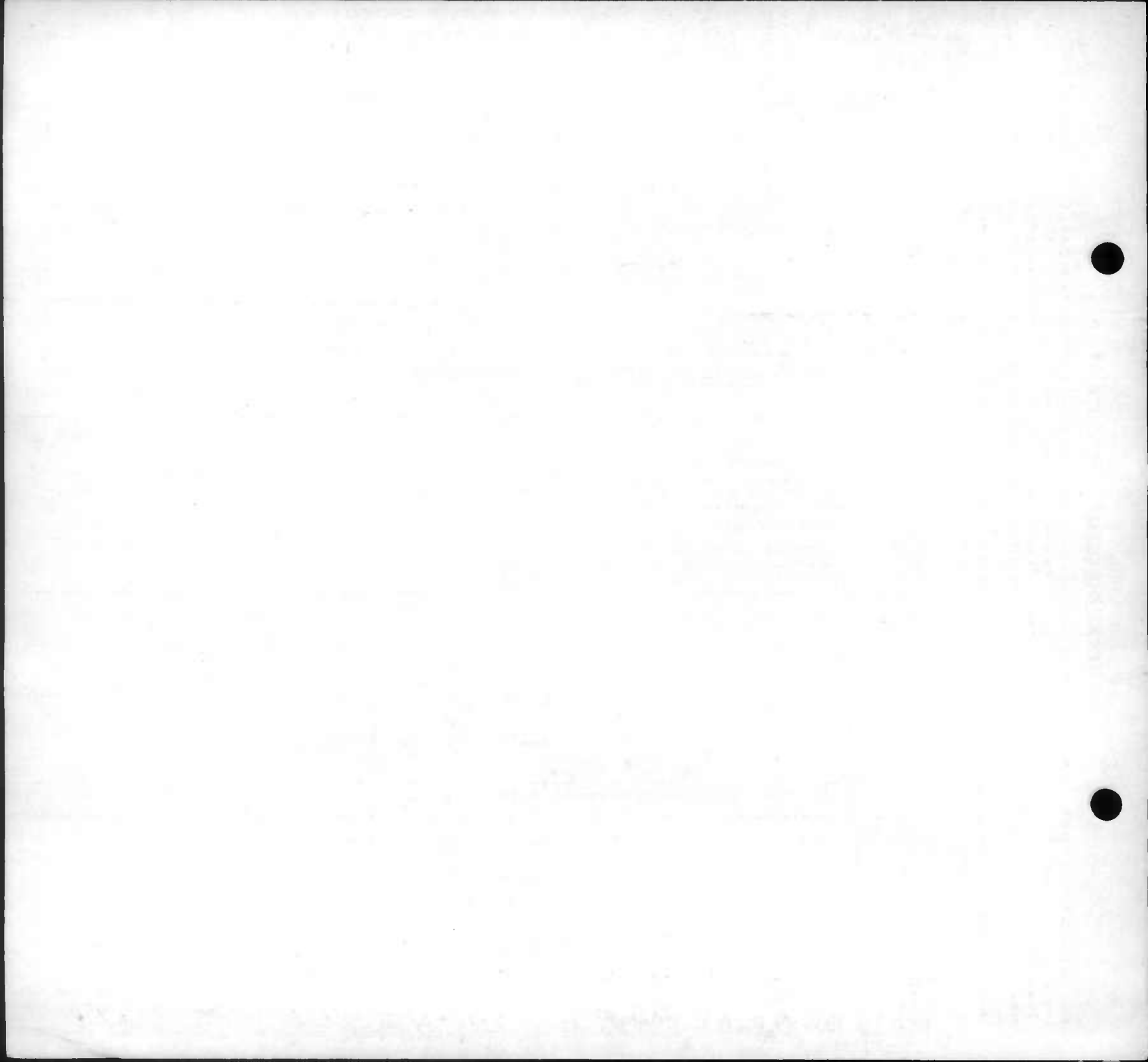
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No.	
BIRTH NO.		65 12628		65 12628			
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
JAMES CYRUS				12-9-65 5:15 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
THE JOHNS HOPKINS HOSPITAL 601 N. BROADWAY BALTIMORE, MD 21205				MARYLAND - BALTIMORE			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				D. STREET ADDRESS (If rural, give location)			
Aerea cres (20)				40 LEFTWING DRIVE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
M	W	MARRIED	7-10-05	60			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Service Dept. Attendant			Auto Agency		West Virginia		USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
THOMAS Cyrus				LULA MC COMAS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No --		232 18 5344		Mary Cyrus Same			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				? Pulmonary Emboli 8 hours			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				ASCVD			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from 12-9-65 to 12-9-65, that (I) (we) last saw the deceased alive on 12-9-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
NICHOLAS J. FORTUIN						12-9-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
NICHOLAS J. FORTUIN				JOHNS HOPKINS HOSPITAL-BALTO. MD			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12/11/65		Oak Lawn Cemetery		Baltimore Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR'S ADDRESS			
DEC 13 1965		Robert E. Fodor		Brazdzinski Funeral Home 1407 Eastern Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>65 12629</u>	
BIRTH NO. <u>65-30220</u>		65 12629					
M.E. CASE NO.				2. DATE AND HOUR OF DEATH <u>12/8/65</u> <u>9:15</u> A.M.			
1. NAME OF DECEASED (Type or Print) <u>Baby Girl Tressler</u>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>31 Baltimore City Hospital</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
				D. STREET ADDRESS (If rural, give location) <u>27 Lakeside Lane 2531 Yorkway #22</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never</u>	8. DATE OF BIRTH <u>12/8/65</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jack Tressler</u>				14. MOTHER'S MAIDEN NAME <u>Peggie Spicer</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. <u>776X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Immaturity</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>8/12/65</u> <u>7:35 AM</u> <u>19 65</u> to <u>9:15</u> <u>8/12/65</u> <u>19 65</u> , that (I) (we) lost saw the deceased alive on <u>8/12/65</u> <u>19 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Jere P. Smith</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12/8/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Jere P. Smith</u>				23D. ADDRESS <u>Baltimore City Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-10-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Gardens of Faith</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1965</u>		25B. NAME OF REGISTRAR <u>R. E. T. T. T.</u>		25C. FUNERAL DIRECTOR <u>1905 Quindall-Walter Dabowski</u>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

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65 12630		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		CERTIFICATE OF DEATH	
M.E. CASE NO.		Registered No. 65 12630	
1. NAME OF DECEASED (Type or Print) Joy, JOHN T.		2. DATE AND HOUR OF DEATH 12-8-1965 8:40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 91 MONTERBELLO STATE HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND. B. COUNTY PASADENA AA C. CITY OR TOWN (If outside city limits, write RURAL and give township) CHELSEA BEACH 52-00 D. STREET ADDRESS (If rural, give location) ✓	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-17-1904
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat cutter		10B. KIND OF BUSINESS OR INDUSTRY Grocery	9. AGE (In years last birthday) 61
11. BIRTHPLACE (State or foreign country) FREDRICK, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME XXXXXXXXXX Charles Edw. Joy		14. MOTHER'S MAIDEN NAME XXXXXXXXXX Mary Catherine Harp	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-703159	
17. INFORMANT Mr. T. Edward Joy Frederick, Maryland		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinoma of Rectum (B) Metastasis (C) _____ INTERVAL BETWEEN ONSET AND DEATH about 3 years			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10-25-1965 to 12-8-1965 , that (I) (we) last saw the deceased alive on 12-8-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Zin U. Park		23B. DATE SIGNED 12-8-65	
23C. PHYSICIAN'S NAME (Type) ZIN U. PARK		23D. ADDRESS MONTERBELLO STATE HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-11-1965	
24C. NAME OF CEMETERY or CREMATORY Fairmount Cemetery		24D. LOCATION (City, town, or county) (State) Libertytown, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR Robert E. Dailey & Son	
25C. FUNERAL DIRECTOR Robert E. Dailey & Son		ADDRESS Frederick, Md.	

Burial 12-11-1962 Fairmount Cemetery Libertytown, Maryland
Robert E. Bailey & Son Frederick, Md.

Meat center
Grocery
XXXXXXXXXX Charles Edw. Joy
XXXXXXXXXX Mary Catherine Harp
Mr. T. Edward Joy Frederick, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

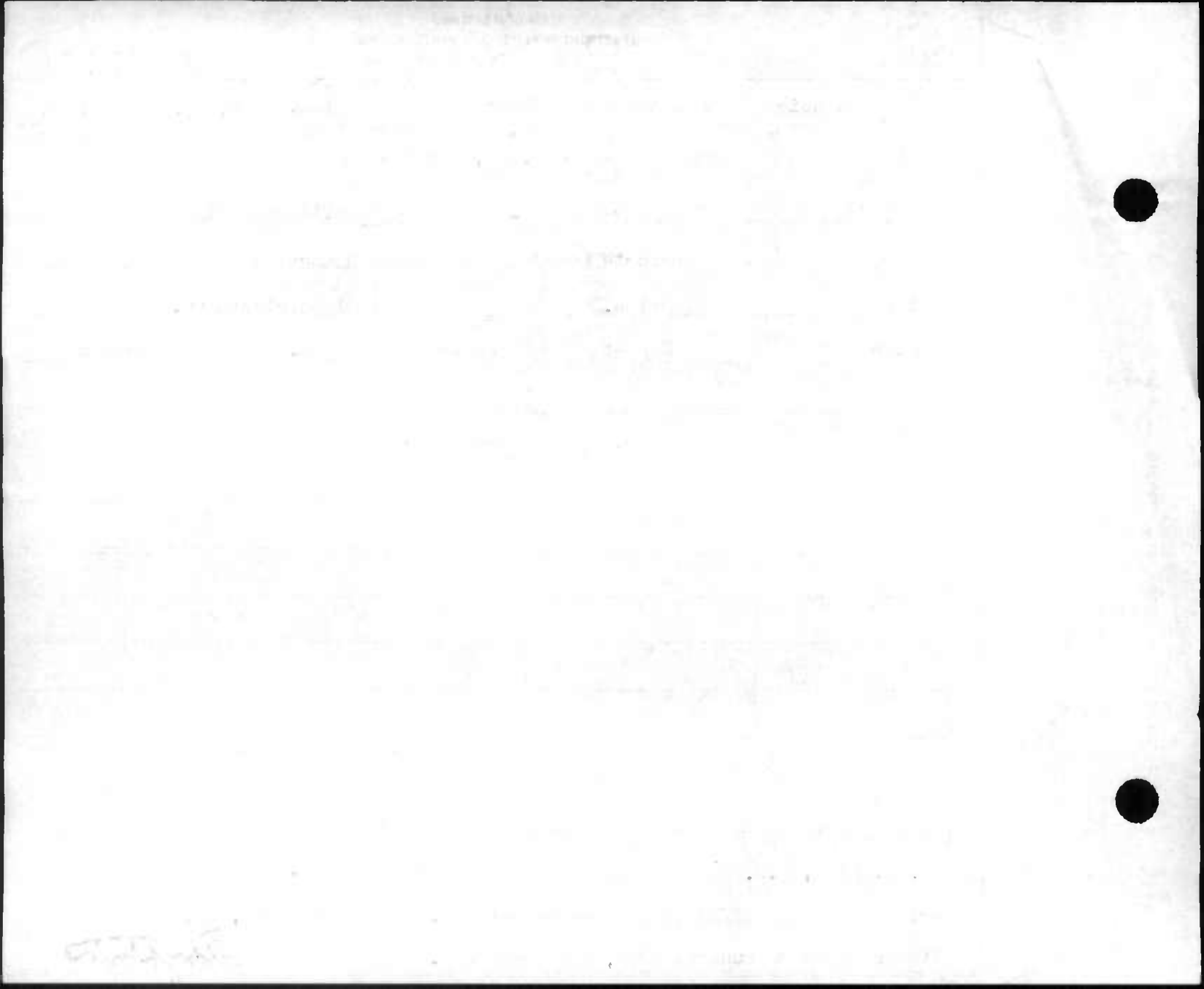
FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 65-12631

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nannie Kensett Reeder			2a. DATE OF DEATH MONTH DAY YEAR December 9, 1965		2b. HOUR 7:30A M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 21, 1885		6. AGE (IN YEARS LAST BIRTHDAY) 80	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 101 Charlcoate Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 101 Charlcoate Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST John Kensett		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie M. Dryden			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (1) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>J. D. King</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/9/65	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. D. King, M.D.		22e. ADDRESS 222 Goldspring La.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/11/65	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR NAME Stewart & Mowen Funeral Home, 108 North Ave.		25a. DATE REC'D. BY REGISTRAR Dec. 12, 1965		25b. REGISTRAR'S SIGNATURE <i>Sidney H. Hinton</i>	

BP



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

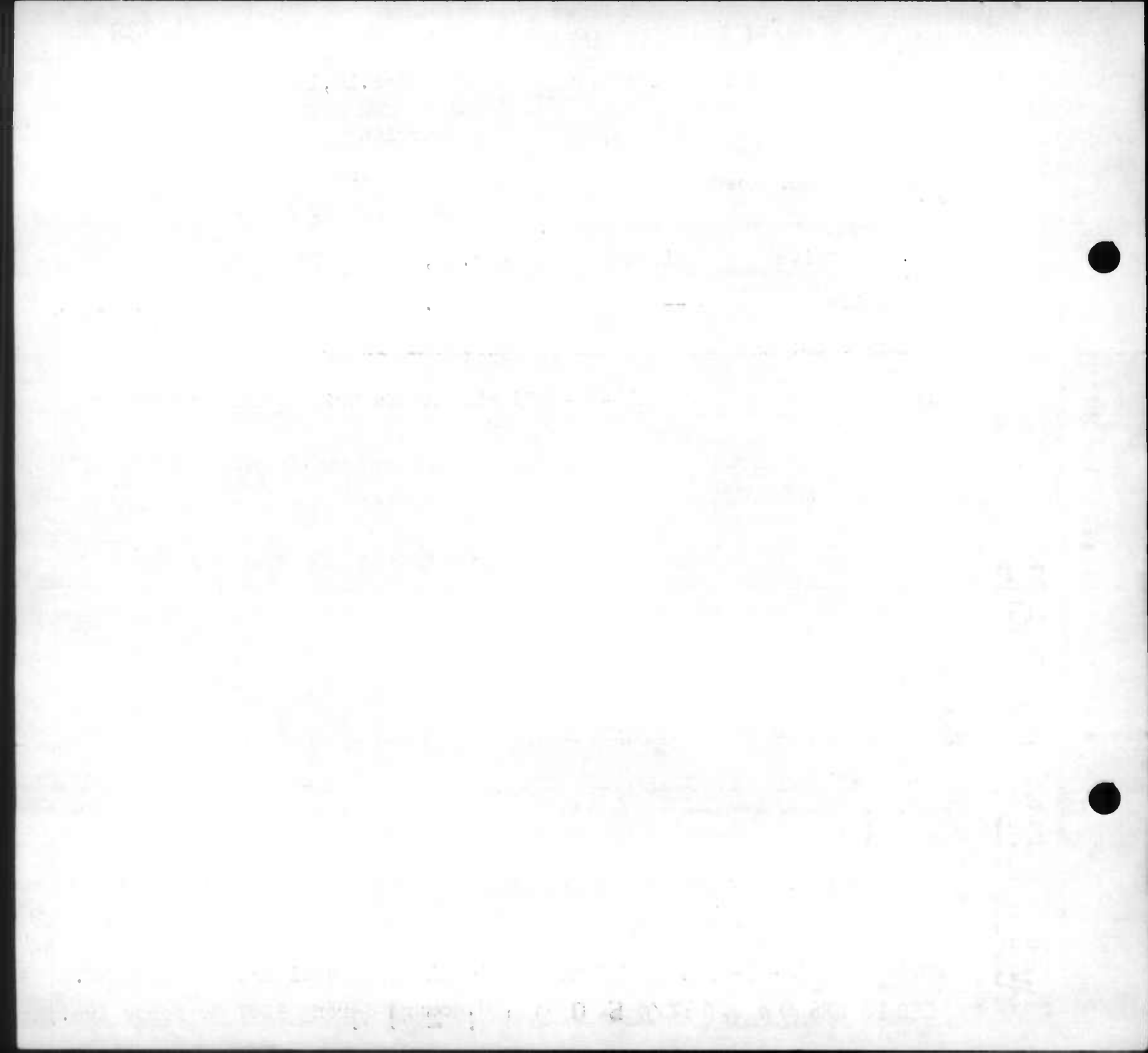
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12632
65 12632		CERTIFICATE OF DEATH		
BIRTH NO.		DATE AND HOUR OF DEATH		
M.E. CASE NO.		12 10 65 12NOON M.		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
JOSEPH PETER CEPURNO				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL WILKENS & CATON BALTO 29 MD		A. STATE MARYLAND		
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 30		
D. STREET ADDRESS (If rural, give location) 1803 CASADEL AVENUE				
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3/30/87	9. AGE (In years last birthday) 78
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TAILOR		10B. KIND OF BUSINESS OR INDUSTRY MANUFACT CO		11. BIRTHPLACE (State or foreign country) LITHUANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME GEORGE CEPURNO		14. MOTHER'S MAIDEN NAME ROSE ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216 05 0279		17. INFORMANT ST AGNES HOSP RECORDS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <i>Cancer of the lungs -</i> DUE TO <i>Massive Myocardial Infarction -</i> (C)		
INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 12 3 19 65 to 12 10 19 65, that (I) (we) last saw the deceased alive on 12 10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>P. Porcell</i>				23B. DATE SIGNED 12/10/65
23C. PHYSICIAN'S NAME (Type) PEDRO P. PORCELL, M.D.		23D. ADDRESS ST Agnes Hospital -		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/13/65	24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem		24D. LOCATION (City, town, or county) (State) Baltimore Md.
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR J. J. Cowan		25C. FUNERAL DIRECTOR J. J. Cowan & Son Inc. Baltimore Md.

31.2.1.10.2.1.1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
65 12633 CERTIFICATE OF DEATH					Registered No. 65 12633				
BIRTH NO. M.E. CASE NO.					1. NAME OF DECEASED (Type or Print)				
Ruth Winchester					2. DATE AND HOUR OF DEATH Dec. 10, 1965				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 106 Upmanor Road					A. STATE Maryland				
					B. COUNTY 28-04				
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					D. STREET ADDRESS (If rural, give location)				
Baltimore					106 Upmanor Road				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Female	White	Widowed	Mar. 16, 1886	79	Housewife	--	Va.	U. S. A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Walter Wright					Addie Taylor				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
no					216-32-5975		Miss Maude Wright 106 Upmanor Road		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from July 19 64 to 10 Dec 19 65, that (I) (we) last saw the deceased alive on 9 Dec 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE William J. Bryson					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 10 Dec. 65	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
William J. Bryson					M.D. 4605 Edmondson AVE, Btto. 29				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
Burial		12-13-1965		Baltimore National			Baltimore Md.		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS			
DEC 13 1965			G. Howard Sprong			3207 W. North Ave.,			



65 12634

BALTIMORE CITY HEALTH DEPARTMENT

65 12634

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

NOEL

NICOLL

2. DATE AND HOUR PRONOUNCED DEAD

December 8, 1965

11:00 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

40 St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1037 Craftswood Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

1/6/44

9. AGE (In years
last birthday)

21

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Secretary

10B. KIND OF BUSINESS OR INDUSTRY

Johns Hopkins Med. Sch.

11. BIRTHPLACE (State or foreign country)

Dothan, Alabama

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Robert W. Delhamer

14. MOTHER'S MAIDEN NAME

Mary E. McGee

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Frank S. Nicoll III-1073 Craftswood Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple Traumatic Injuries.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Parking Lot

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

Craftswood and Robindale Roads

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12 8 '65 P

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
12/9/6523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/11/65

23C. NAME OF CEMETERY or CREMATORY

Mt. Olive Cemetery

23D. LOCATION (City, town, or county)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 13 1965

24B. NAME OF REGISTRAR

R. E. Jackson

24C. FUNERAL DIRECTOR

Loring Byers-8728 Liberty Rd. Randallstown
Md.

WALTER H. HARRIS

1/10/44

1/10/44

U S A

Johns Hopkins Med. Sch. Baltimore, Maryland

Secretary

Harry H. Hulse

Robert F. Hulse

1-28

Dr. Frank A. Harrell III, 111-1013 Crawford St.

to

Baltimore, Md.

cc. Olive Cemetery

1/10/44

1/10/44

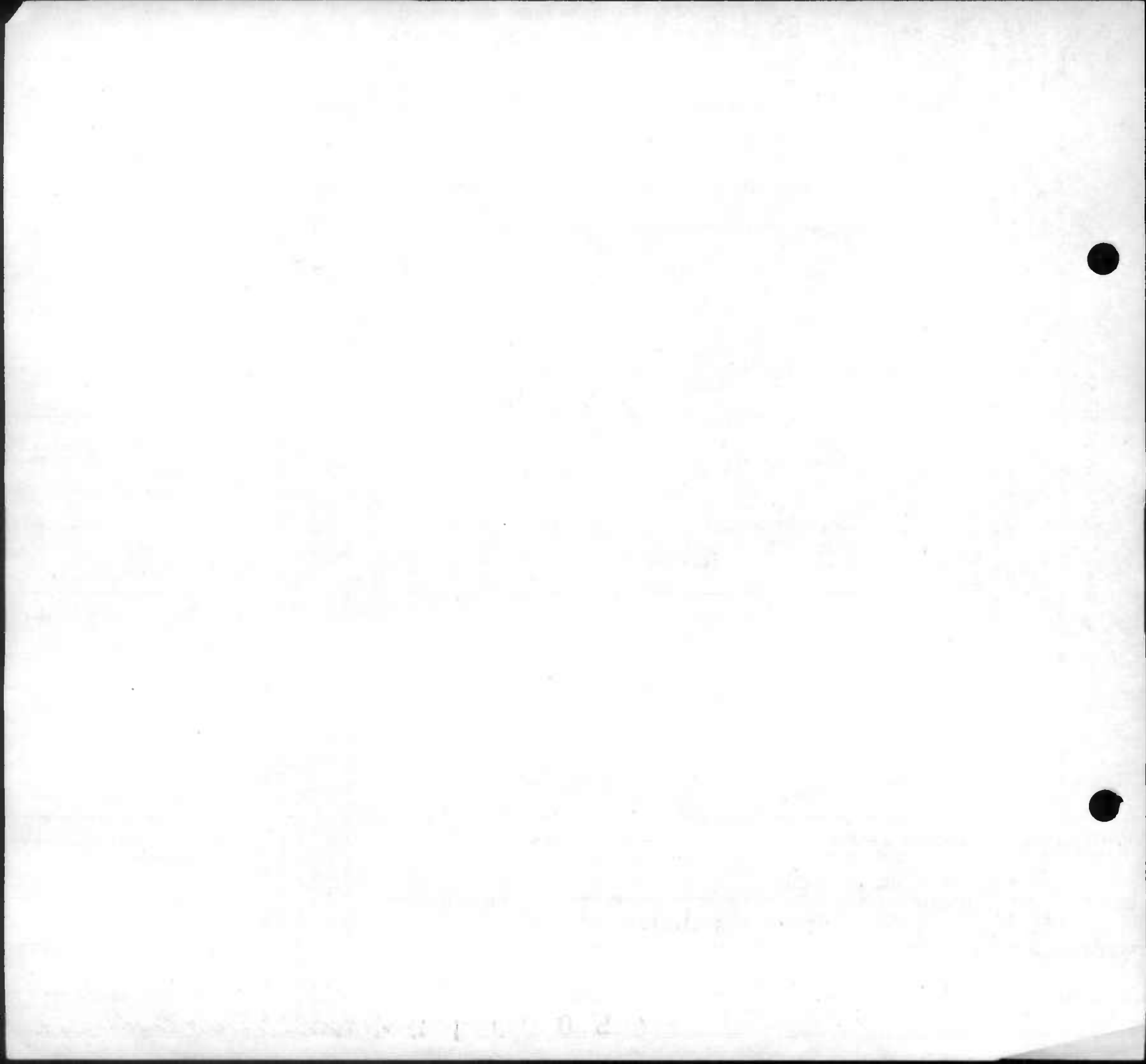
Living Years-1938 Liberty St. Philadelphia

1/10/44

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT															
65 12635					CERTIFICATE OF DEATH					Registered No. 65 12635					
BIRTH NO.					1. NAME OF DECEASED (Type or Print) <i>William A. Prater</i>					2. DATE AND HOUR OF DEATH <i>12-10-65</i> <i>7:00 P</i> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)										
FULL NAME OF HOSPITAL OR INSTITUTION <i>38 University</i>					A. STATE <i>Maryland</i>					B. COUNTY <i>16-03</i>					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>										
					D. STREET ADDRESS (If rural, give location) <i>925 Vincent St</i>										
5. SEX <i>Male</i>		6. RACE <i>Negro</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>		8. DATE OF BIRTH <i>9-12-01</i>		9. AGE (In years last birthday) <i>64</i>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Contractor's Jobs</i>				11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Joshua Prater</i>					14. MOTHER'S MAIDEN NAME <i>Frances</i>										
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>					16. SOCIAL SECURITY NO. <i>28-18-9213</i>					17. INFORMANT ADDRESS <i>Hospital Records</i>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <i>Myocardial Infarction</i> DUE TO					INTERVAL BETWEEN ONSET AND DEATH <i>60 days</i>					
					(B) <i>HASCU</i> DUE TO										
					(C) _____										
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					19A. DATE OF OPERATION <i>11-1-65</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Sanguine PD Foot 2nd ASD</i>					
					20A. AUTOPSY? (Yes or No) <i>No</i>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>No</i>					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>No</i>					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <i>No</i>					21E. INJURY OCCURRED While At Work <input type="checkbox"/> <i>No</i> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR? <i>No</i>					
22. I certify that (1) (this hospital) attended the deceased from <i>10-8</i> 19 <i>65</i> to <i>12-10</i> 19 <i>65</i> , that (1) (we) last saw the deceased alive on <i>12-10</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.															
23A. SIGNATURE <i>Henry A. Saiontz</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <i>12-10-65</i>					
23C. PHYSICIAN'S NAME (Type) HENRY A SAIONTZ					23D. ADDRESS M.D.										
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>12-15-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Mem. PK</i>			24D. LOCATION (City, town, or county) (State) <i>Arbutus, MD.</i>							
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965					25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>					25C. FUNERAL DIRECTOR ADDRESS <i>1348 N. Calhoun St.</i>					



65 12636

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12636

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT

EARL

RUTH

2. DATE AND HOUR PRONOUNCED DEAD

December 10, 1965

8:05 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2515 Riggs Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

July 10, 1919

9. AGE (In years
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Ruth

14. MOTHER'S MAIDEN NAME

Lula Molton

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Flossie Ruth 2515 Riggs Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic Cardiovascular Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
12/10/6523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/14/65

23C. NAME of CEMETERY or CREMATORY

Balto. Natl. Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 13 1965

24B. NAME OF REGISTRAR

Robert E. Ferguson

24C. FUNERAL DIRECTOR

ADDRESS

1348 N. Carbon St

WALTON

July 12, 1919

Wanted

John A. C.

John A. C.

Wanted

Wanted

Wanted

Wanted

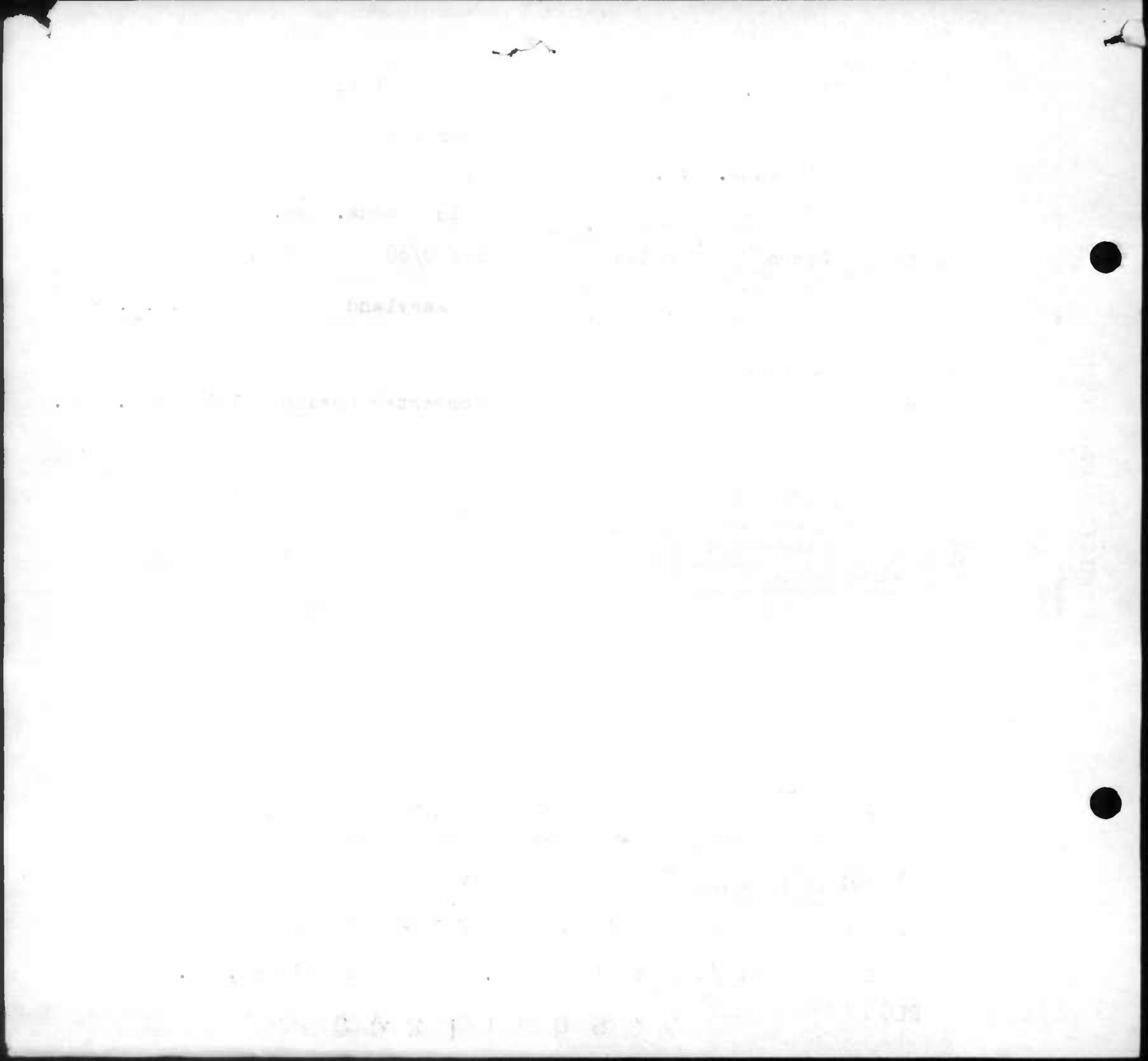
Wanted

Wanted

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

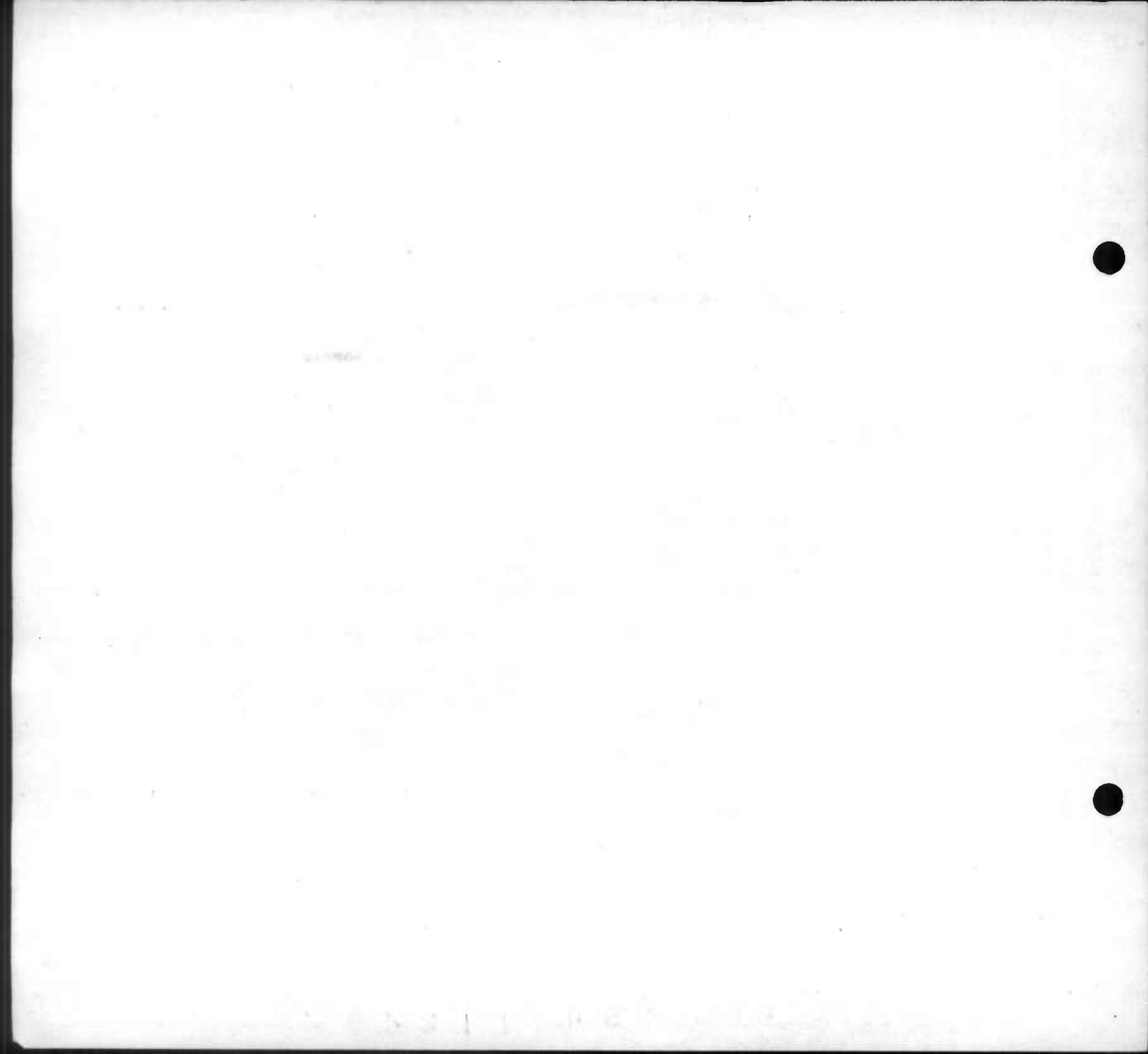
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. 65 12637	
BIRTH NO. 65 12637		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) Flora S. Bryson		2. DATE AND HOUR OF DEATH 12/10/65 9:45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 14-03			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2131 Penna. Ave.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 2131 Penna. Ave.			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 11/29/88	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Forrester Bryson 2131 Penna. Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 443 XI		CAUSE OF DEATH (A) CARDIO VASCULAR DISEASE DUE TO (B) HYPERTENSION DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 5 YRS. 5 YRS.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from DEC 4 1960 to DEC. 10 1965, that (I) (we) last saw the deceased alive on DEC. 8 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE William Frey M.D.				23B. DATE SIGNED 12/13/65	
23C. PHYSICIAN'S NAME (Type) WILLIAM FREY M.D.				23D. ADDRESS 1938 PENNA. AVE.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/13/65		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem.	
		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR Robert E. Sullivan		25C. FUNERAL DIRECTOR ADDRESS 1518 N. Calhoun St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 12638		CERTIFICATE OF DEATH		65 12638	
1. NAME OF DECEASED (Type or Print) Robert L. Parker			2. DATE AND HOUR OF DEATH December 9, 1965 12:00 a.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 39 Provident Hospital 1514 Division Street Baltimore, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 14-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1842 Penmont Ct.		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH 12/18/27	9. AGE (In years last birthday) 37	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemical Worker			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Roy Parker		
14. MOTHER'S MAIDEN NAME Elenoria V. Norris			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		
16. SOCIAL SECURITY NO.			17. INFORMANT Elenoria V. Palmer 418 N. Payson St		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 393 X I Acute Renal failure with Acute pulmonary edema.			INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II Very Severe Anemia due to G-i Bleeding.			20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from November 30, 1965 to December 9, 1965 , that (I) (we) last saw the deceased alive on December 9, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Rigaud				23B. DATE SIGNED 12/9/65	
23C. PHYSICIAN'S NAME (Type) A. Rigaud				23D. ADDRESS 1514 Division Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/13/65		24C. NAME OF CEMETERY or CREMATORY Burial	
24D. LOCATION (City, town, or county) (State) Baltimore		25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965			
25B. NAME OF REGISTRAR Robert L. Parker		25C. FUNERAL DIRECTOR May 1965 638 N. Payson St			



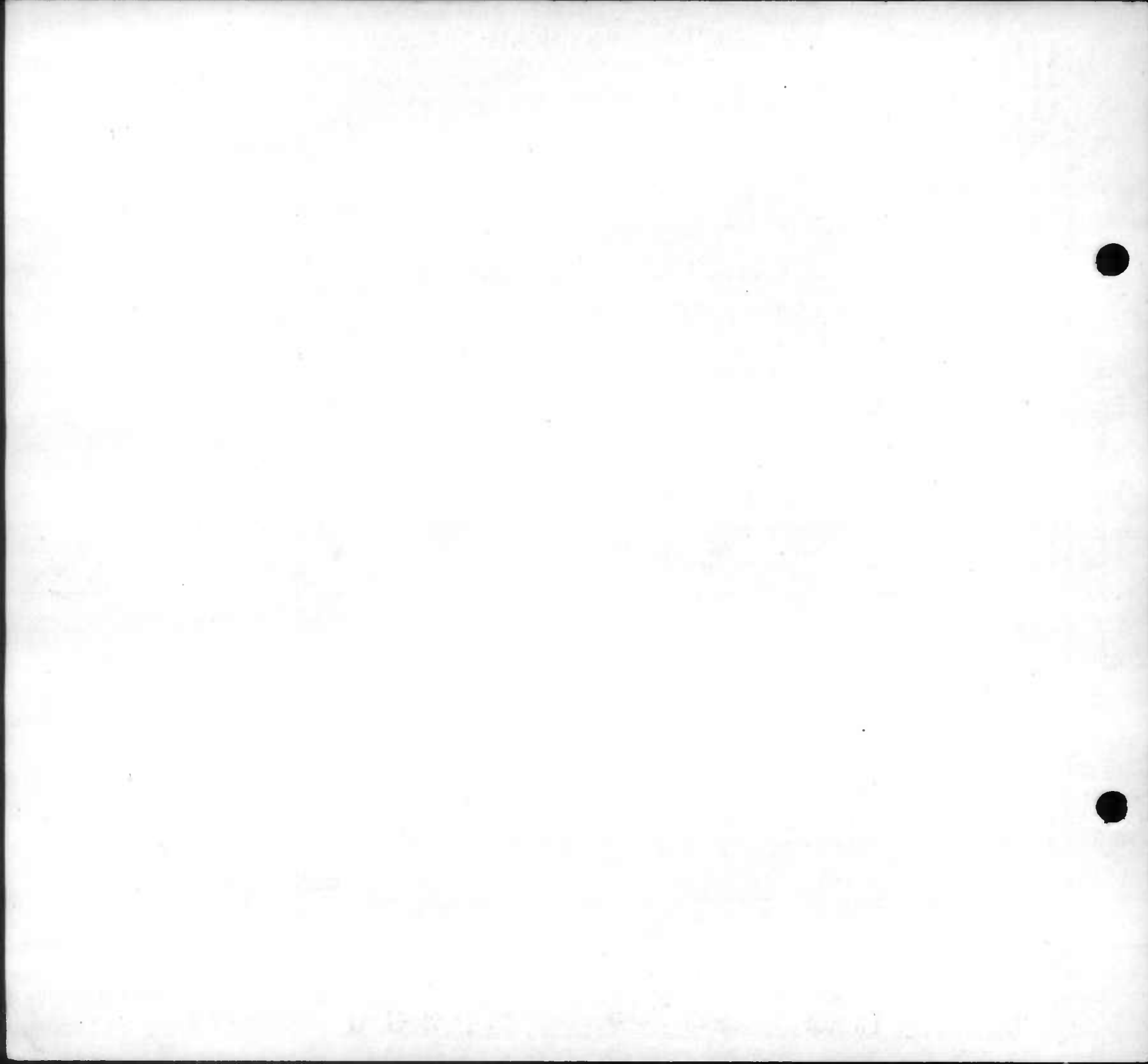
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 65 12639

BIRTH NO. <u>65 12639</u>		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <u>CLIMMIE T. YANCY</u>		2. DATE AND HOUR OF DEATH <u>DEC 8 - 1965</u> <u>3:00 P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>DO</u> <u>1623 W. FRANKLIN ST</u> (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>19-01</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO</u> D. STREET ADDRESS (If rural, give location) <u>1623 W. FRANKLIN ST</u>	
5. SEX <u>FC</u>	6. RACE <u>colored</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>65</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	9. AGE (In years last birthday) <u>65</u>
11. BIRTHPLACE (State or foreign country) <u>GEORGIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES T. MORRIS</u>		14. MOTHER'S MAIDEN NAME <u>SALLY MORRIS</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>JAMES P. MORRIS / 1623 W. FRANKLIN</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>422.11</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <u>Arteriosclerosis</u> DUE TO (B) <u>Cardio-vascular Disease</u> DUE TO (C) <u>18 months</u> INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April 23</u> 19 <u>65</u> to <u>Dec 8</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Dec 8</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Ralph W. Becklin</u>		23B. DATE SIGNED <u>12/10/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Ralph W. Becklin</u>		23D. ADDRESS <u>426 N. Gilman Street Balto Md</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>12/11/65</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn</u>	24D. LOCATION (City, town or county) (State) <u>Baltimore</u>
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>	
25C. FUNERAL DIRECTOR <u>Manly G. Rogers</u>		ADDRESS <u>658 W. Gilman St</u>	



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Charlotte HUGHES

2. DATE AND HOUR PRONOUNCED DEAD

Dec., 11, 1965

4:05 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1005 N. Carrollton Ave.

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

2-11-1945

9. AGE (In years last birthday)

17

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

SEMOBA N.C.

12. CITIZEN OF WHAT COUNTRY?

USA.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Josephine Hughes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Josephine Hughes 1005 N. Carrollton

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Grand mal epilepsy

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Dec. 12, 1965

23A. BURIAL CREMATION, REMOVAL (Specify)

Removal

23B. DATE

12/14/65

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

SEMOBA - N.C.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 13 1965

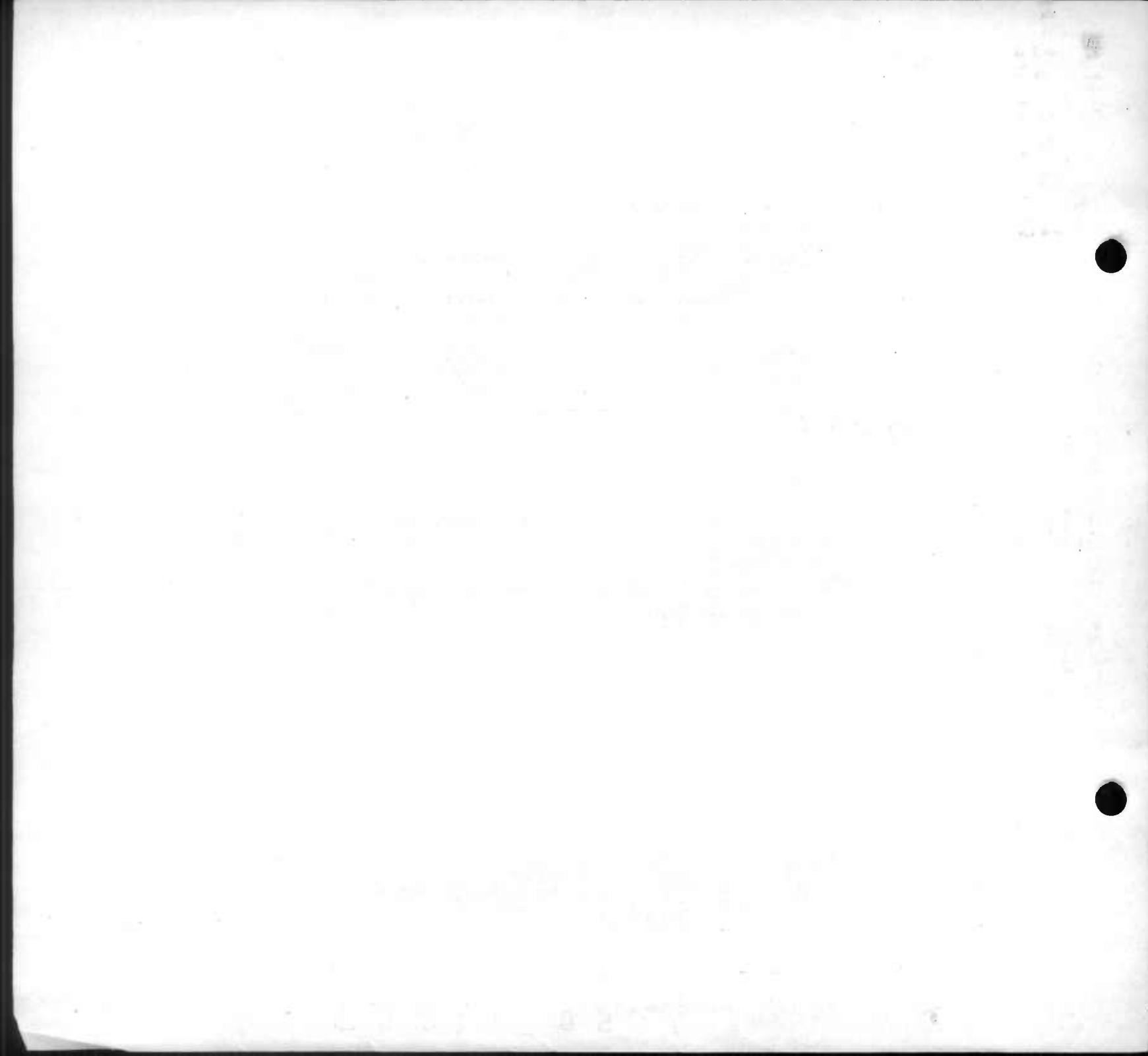
R. E. A. P. F. J. J. J.

Morgan P. Jones 638 N. G. M. St

WALLEY FORDGE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributory cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12641		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12641	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Alexander R. Carr		2. DATE AND HOUR OF DEATH 12/11/65 10:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 203			
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21231			
		D. STREET ADDRESS (If rural, give location) 515 South Chapel Street			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 2-11-01	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Park Board City		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Alexander Carr			
14. MOTHER'S MAIDEN NAME Katherine Hamilton		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 217-03-1827		17. INFORMANT ADDRESS Raymond C. Carr 8026 Wyndbrook Road			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 5-27-11		CAUSE OF DEATH (A) DUE TO Cardiac arrest myocardial infarction (B) DUE TO Coronary Emphysema Chronic obstructive pulmonary disease (C) _____		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 5-15 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/9 19 65 to 12/11 19 65 , that (I) (we) last saw the deceased alive on 12/11 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. Eugene Page		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/11/65	
23C. PHYSICIAN'S NAME (Type) E. Eugene Page		23D. ADDRESS Johns Hopkins Hospital, Balt. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-15-1965		24C. NAME OF CEMETERY or CREMATORY Oak Lawn	
24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965			
25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901 Eastern Ave.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12642		CERTIFICATE OF DEATH		Registered No. 65 12642	
M.E. CASE NO. GEORGE W. BETZ					
1. NAME OF DECEASED (Type or Print) Mr. George Betz		2. DATE AND HOUR OF DEATH 11-12 Dec. 12, 1965 5:07A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 Church Home Hospital 12-17-65		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-25			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 6708 Hudson St. # 24			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 8-05-08	9. AGE (In years last birthday) 57
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10B. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co.		11. BIRTHPLACE (State or foreign country) Md Baltimore	
13. FATHER'S NAME John Betz		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-10-4986		17. INFORMANT Mrs. Anna Betz ADDRESS 6708 Hudson Street	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
				Acute Myocardial Infarction minutes	
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-11 19 65 to 12-12 19 65 , that (I) (we) last saw the deceased alive on Dec. 12-11-65 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. E. Subong M.D.				23B. DATE SIGNED Dec. 12th 65	
23C. PHYSICIAN'S NAME (Type) A. E. Subong, Jr.				23D. ADDRESS Church Home Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-15-1965		24C. NAME OF CEMETERY or CREMATORY Oak Lawn	
24D. LOCATION Baltimore County, Maryland					
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Lilly & Zeiler Inc. ADDRESS 1901 Eastern Ave.	

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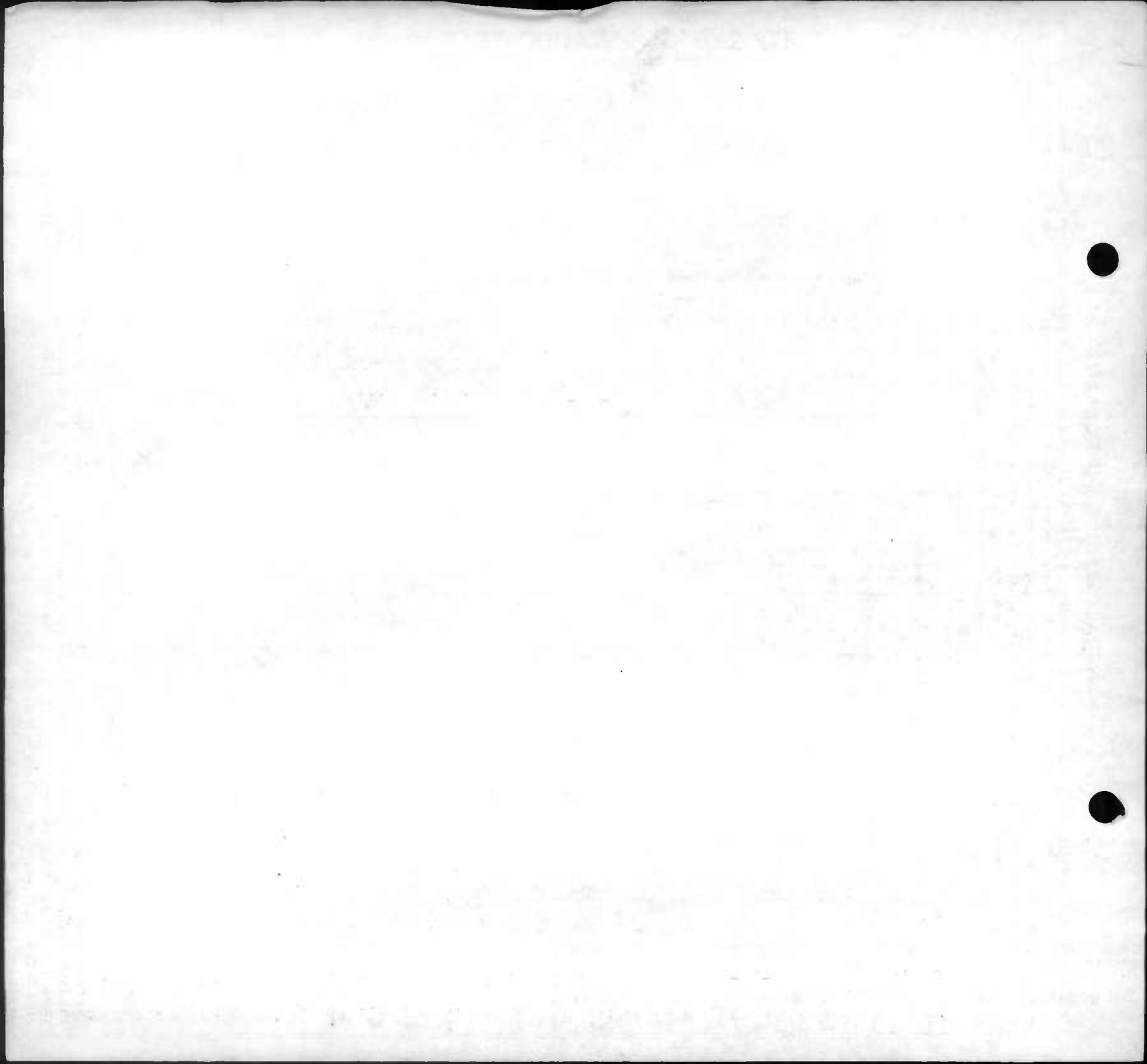
Handwritten notes, possibly a list or address, mostly illegible.

Handwritten notes, possibly a list or address, mostly illegible.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

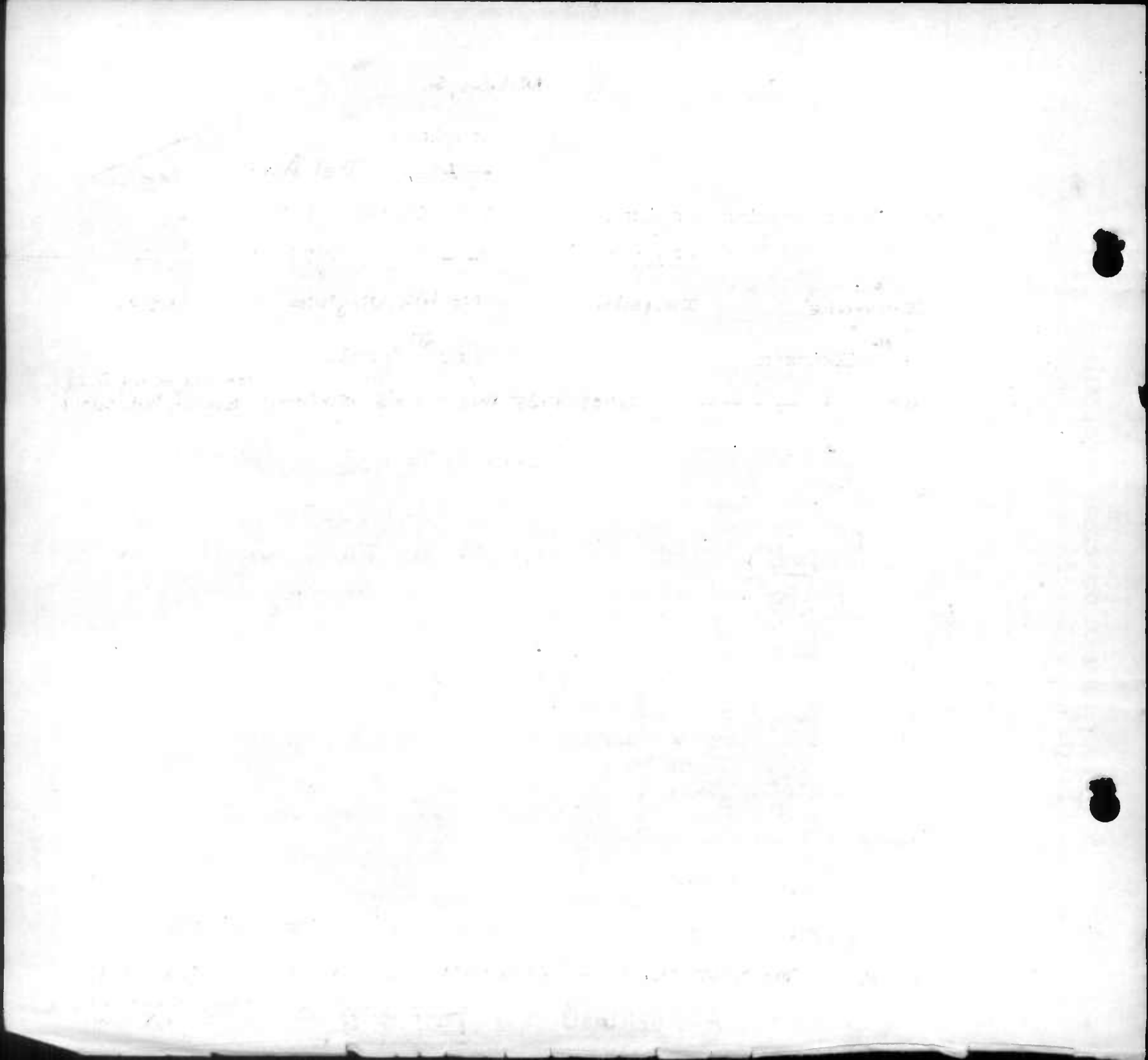
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12643	
BIRTH NO. 65 12643				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) RACHEL A. DILLE				12-10-65 12:40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) B7 Mercy Hospital				A. STATE MARYLAND B. COUNTY 26-07	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
				D. STREET ADDRESS (If rural, give location) 920 Ponca St.	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-13-08	9. AGE (In years last birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME RAYMOND WINNER			14. MOTHER'S MAIDEN NAME ALICE B. BROUGH		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-16-6019	17. INFORMANT ADDRESS William Dille 920 Ponca Street		
18. 420.1 L 1 260 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiac Stenosis				INTERVAL BETWEEN ONSET AND DEATH 15 min.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Complete A.V. Block.				3 hours.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute Myocardial Infarction.				Diabetes Mellitus.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White A <input type="checkbox"/> Not White <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-9-65 19 to 12-10-65 19 that (I) (we) last saw the deceased alive on 12-10-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Blenkatchalam				23B. DATE SIGNED 12-10-65	
23C. PHYSICIAN'S NAME (Type) B. VENKATACHALAM				23D. ADDRESS Mercy Hospital, Baltimore Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-14-1965		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park	
				24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS Lilly & Ziller Inc. 1901 Eastern Avenue	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

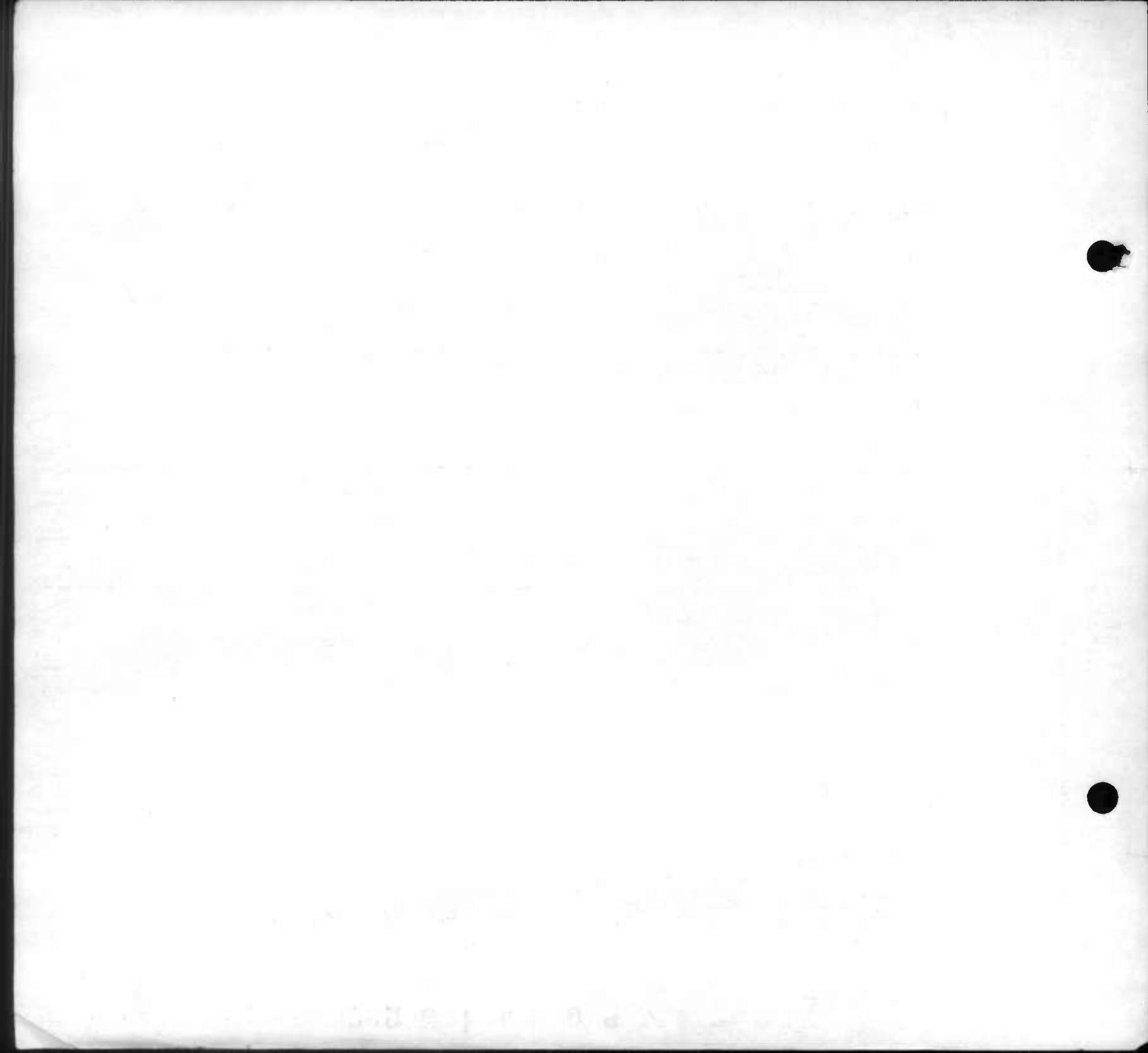
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 12644	
BIRTH NO. 65 12644				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <i>Wilkinson, John Nicholas, Sr.</i>				2. DATE AND HOUR OF DEATH <i>Dec. 8, 1965 12⁴⁰ P. M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital				A. STATE Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Bel Air, BEL Air 6232			
				D. STREET ADDRESS (If rural, give location) 700 Ridgewood Road			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6-4-89	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance		10B. KIND OF BUSINESS OR INDUSTRY Inspector		11. BIRTHPLACE (State or foreign country) Norfolk, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME N- John Wilkinson				14. MOTHER'S MAIDEN NAME J. Mary Bissell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-03-4435		17. INFORMANT With ADDRESS Mrs. CLARE S. Wilkinson 700 Ridgewood Road BEL Air, Md. 21014			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 6/10X I				CAUSE OF DEATH (A) Goom negative septemia/shock 12 hours			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Urinary tract infection 24 hours			
				(C) Prostatic abscess of urethra 1 year			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Severe emphysema, congestive heart failure 5 years.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/2 19 65 to 12/8 19 65 , that (I) (we) last saw the deceased alive on 12/8 19 65 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Allen Johnson</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/8/65	
23C. PHYSICIAN'S NAME (Type) Allen Johnson				23D. ADDRESS M.D. The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec 10, 1965		24C. NAME OF CEMETERY or CREMATORY Churchville Presbyterian Church		24D. LOCATION (City, town, or county) (State) Churchville, Harford Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Joseph William Foster</i> ADDRESS W. Broadway & Williams BEL Air, Md. 21014			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

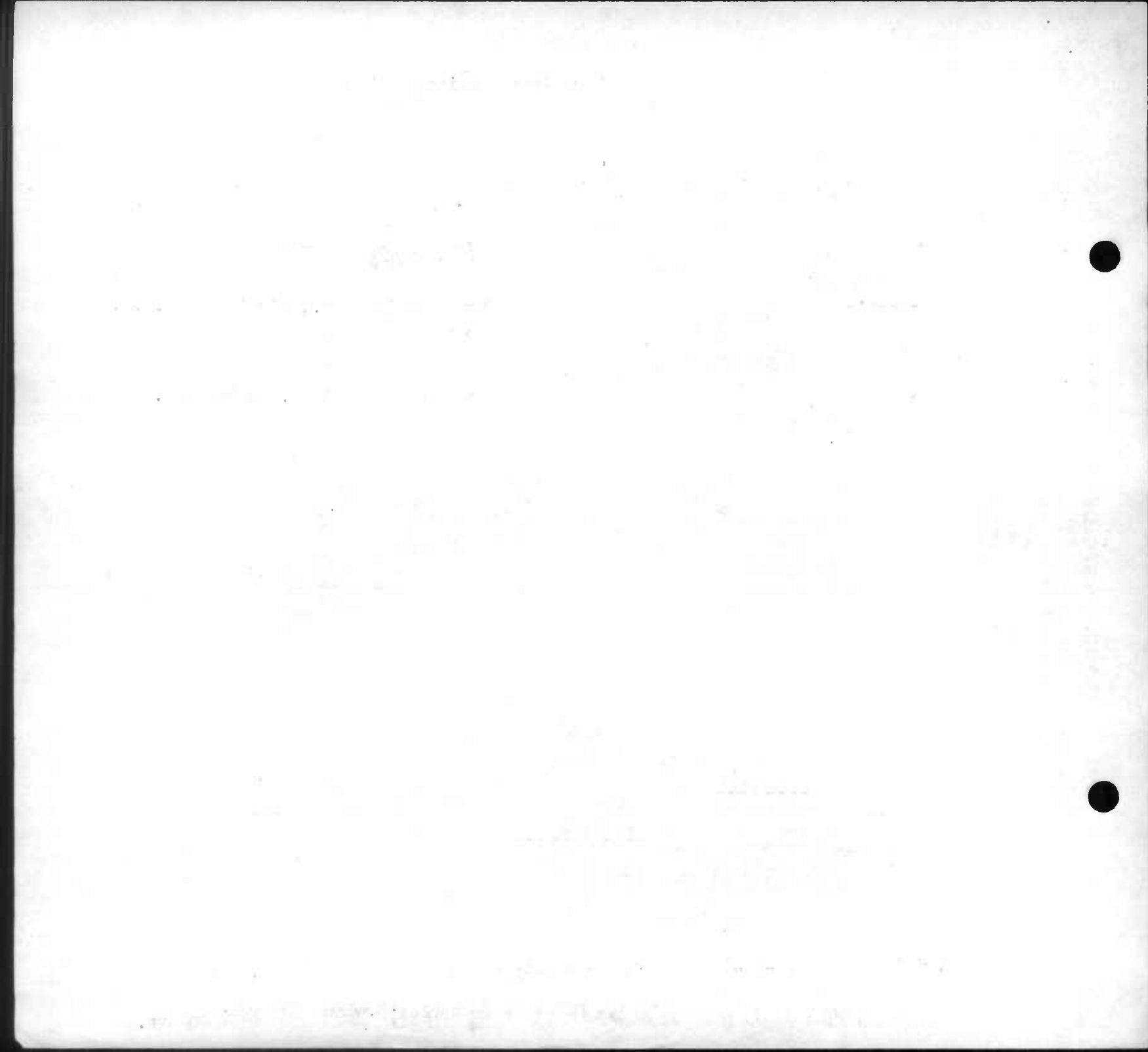
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		65 12645		65 12645	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
FRANK J. Fletcher			8-Dec-65 8:50 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
MARYLAND GENERAL Hospital			MARYLAND Howard		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Edge wood 6200		
			D. STREET ADDRESS (If rural, give location)		
			Willoughby Beach Rd		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
MALE	white	MARRIED	6-7-00	65	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Retired pipe fitter Chemicals			Penn		USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John Fletcher			SARAH Schoff		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
No			220-22-0083	WIFE SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
163X I			(A) Carcinoma of Lung		One year
			DUE TO		
			(B) widespread metastasis		
			DUE TO		
			(C)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			- NO -		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 11:05 PM 28 Nov 19 65 to 8:50 8-Dec-19 65, that (I) (we) last saw the deceased alive on 8 Dec 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
T.C. Cullis MD			8-Dec-65		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
T.C. Cullis MD			Maryland General Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	12/11/65	Emory Cemetery	Street, Howard Maryland.		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS		
DEC 13 1965		Robert E. Fagley	Howard 5-63 Comas Son Abingdon, Md.,		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

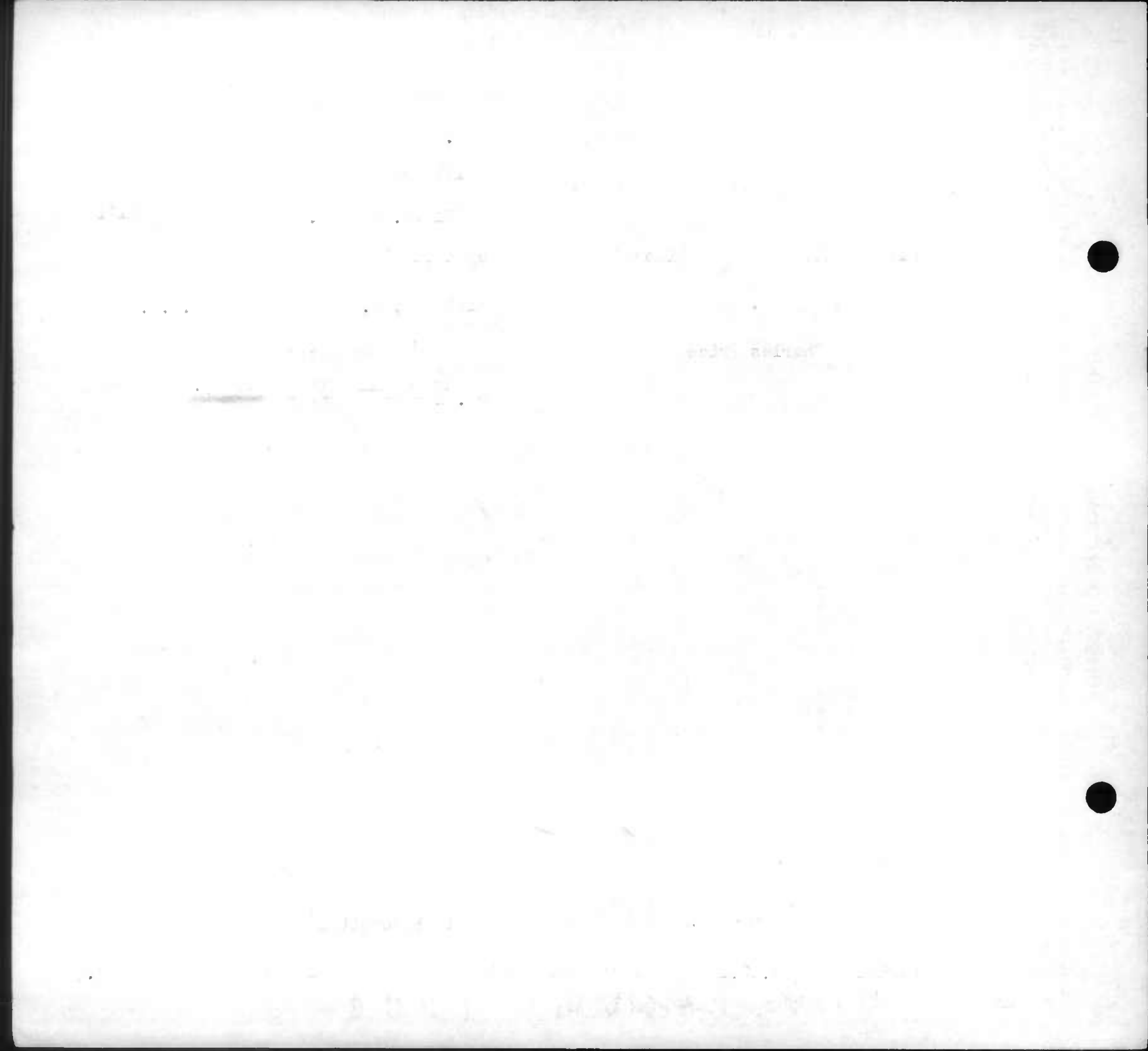
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 12646	
BIRTH NO. 65 12646		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Watkins, Mary</i> (Mary Jane Watkins)		2. DATE AND HOUR OF DEATH <i>12/9/65</i> <i>1:48</i> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Johns Hopkins Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>15-47</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>3021 Quynn Falls Hwy</i>			
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Wid.</i>	8. DATE OF BIRTH <i>12/17/08</i>	9. AGE (In years last birthday) <i>57</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		11. BIRTHPLACE (State or foreign country) <i>Northumberland Co., Virginia</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Northumberland Co., Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Gaskins</i>		14. MOTHER'S MAIDEN NAME <i>Loose Roberson</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Lovey Jones - 617 N. Fulton Ave.</i>		ADDRESS	
18. <i>410X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Cardiac Arrest</i> DUE TO (B) <i>Rheumatic Heart Disease</i> DUE TO <i>with Aortic Stenosis, Aortic Insufficiency, Mitral Stenosis</i> (C)		INTERVAL BETWEEN ONSET AND DEATH <i>5 minutes</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) <i>(this hospital)</i> attended the deceased from <i>12-9</i> 19 <i>65</i> to <i>12-9</i> 19 <i>65</i> , that (1) <i>(we)</i> last saw the deceased alive on <i>12-9</i> 19 <i>65</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (1) <i>(We)</i> <i>(did)</i> <i>(did not)</i> view the body after death.							
23A. SIGNATURE <i>Michael L. Davis</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>12/9-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Michael L. Davis</i>				23D. ADDRESS M.D. <i>The Johns Hopkins Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-13-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Memorial Park</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <i>Charles R. Law</i>		ADDRESS <i>802 Madison Ave.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

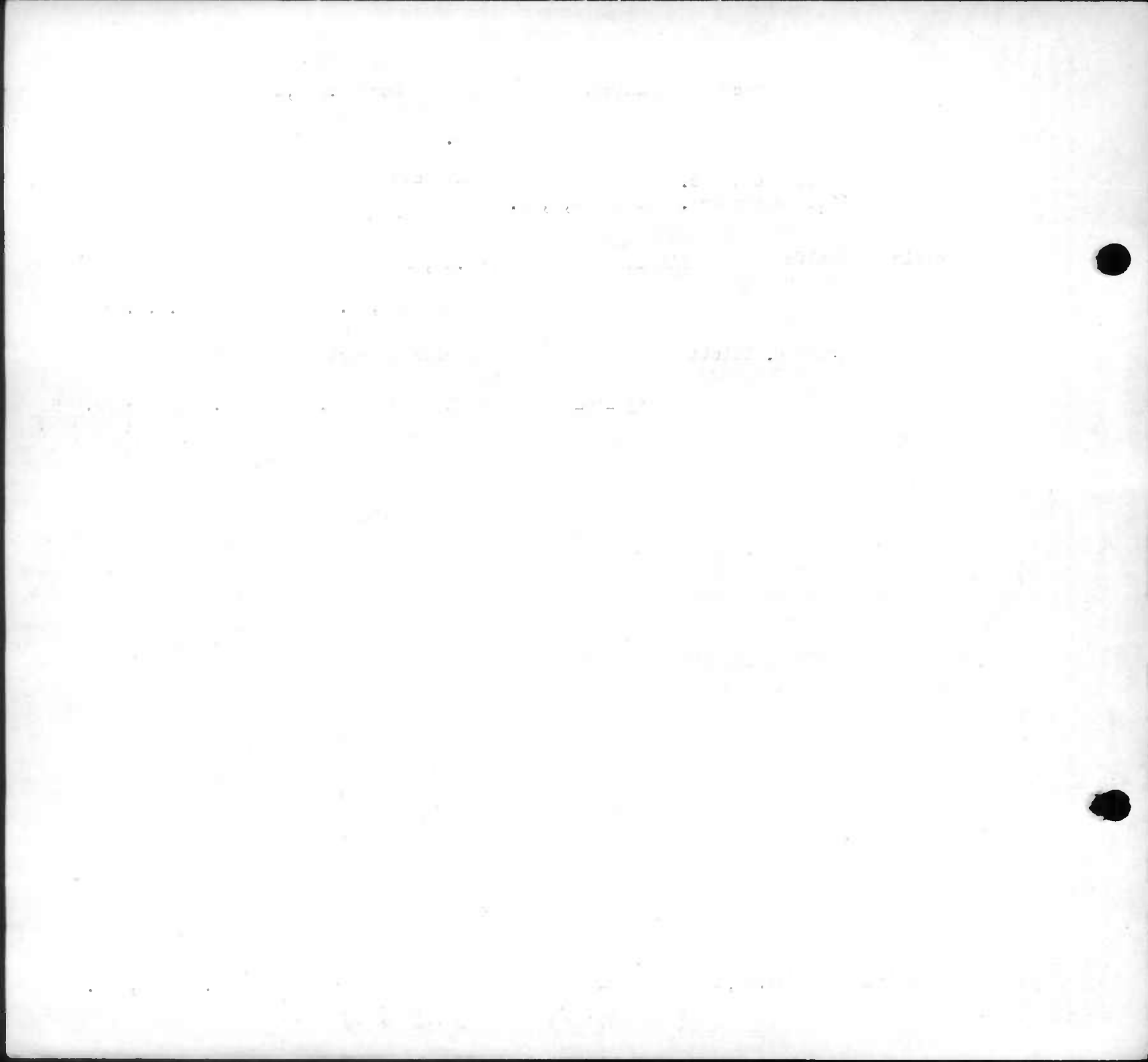
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 12647	
BIRTH NO. 65 12647							
M.E. CASE NO. 65 12647							
1. NAME OF DECEASED (Type or Print) Fanny Simpson				2. DATE AND HOUR OF DEATH 9 Dec 1965 11:20 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hospital of Baltimore				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 12-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3501 St. Paul St. 21218			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH May 18, 1900	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Price				14. MOTHER'S MAIDEN NAME Eva Buckman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Stone Mill Annandale Rd. New Jersey Mrs. Florence Strauss			
18. 420:1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Ventricular Fibrillation DUE TO (B) Acute Myocardial Infarction DUE TO (C) Arteriosclerotic Cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 15 min 16 min	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (he) (this hospital) attended the deceased from 29 Nov 1965 to 9 Dec 1965 , that (I) (we) last saw the deceased alive on 9 Dec 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Solomon Robbins				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9 Dec '65	
23C. PHYSICIAN'S NAME (Type) Solomon Robbins				23D. ADDRESS M.D. Sinai Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 12, 1965		24C. NAME OF CEMETERY or CREMATORY Hebrew Friendship		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR Robert E. Feldman		25C. FUNERAL DIRECTOR Wm. J. Dickner & Sons		ADDRESS N. & Pa. Aves.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 12648					CERTIFICATE OF DEATH			Registered No. 65 12648	
M.E. CASE NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) Grace Elliott					December 9, 1965 11:20 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Wesley Home Inc. 2211 Rogers Ave. Baltimore, 9, Md.					A. STATE Md. 27-15				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 2211 Rogers Ave Balto. 9, Md.				
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Jan. 10, 1885	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles P. Elliott					14. MOTHER'S MAIDEN NAME Amelia Parrish				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 219-20-9670		17. INFORMANT ADDRESS Wealely Home Inc. 2211 W. Rogers Ave. 9				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH I 422.1 Atherosclerotic cardiovascular disease					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last.					(B) DUE TO (C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertrophic arthritis									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 27 February 1957 to 9 December 1965, that (I) (we) lost saw the deceased alive on 7 December 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE John W Barnaby					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED 10 Dec 65		
23C. PHYSICIAN'S NAME (Type) JOHN W BARNABY					23D. ADDRESS M.D. 1531 E North Ave Baltimore Md 21213				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 13, 1965		24C. NAME OF CEMETERY or CREMATORY Oaklawn		24D. LOCATION (City, town, or county) (State) Balto. County, Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR Robert G. [unclear]		25C. FUNERAL DIRECTOR William J. Trickett Home H-Pa One					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12649		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 12649	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ALICE ESTELLE SOUDERS		2. DATE AND HOUR OF DEATH December 10, 1965 10¹⁵ P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 12-16-65 1762 Gorsuch Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 9-07 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore - 21218 D. STREET ADDRESS (If rural, give location) 1762 Gorsuch Avenue			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH May 6, 1899	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Howard Beatty			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no ---			16. SOCIAL SECURITY NO. 215-01-9251		17. INFORMANT ADDRESS Mr. John A. Souders - 1762 Gorsuch Ave.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 331X1 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Cerebral Aneurysm DUE TO (B) Atherosclerosis DUE TO (C) Essential Hypertension		INTERVAL BETWEEN ONSET AND DEATH 4 hrs 20 yrs	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 19 46 to 12/10 19 65 , that (I) (we) last saw the deceased alive on 11/27 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Conrad Richter			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/14/65
25C. PHYSICIAN'S NAME (Type) Conrad Richter			23D. ADDRESS M.D. 3128 Hayford Rd. Balto. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/13/65		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965			
25B. NAME OF REGISTRAR Robert E. Stachura		25C. FUNERAL DIRECTOR ADDRESS H. Sander & Sons, Inc., Balto., Md.			

212-4100

V.S. 153

12-16-65

M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

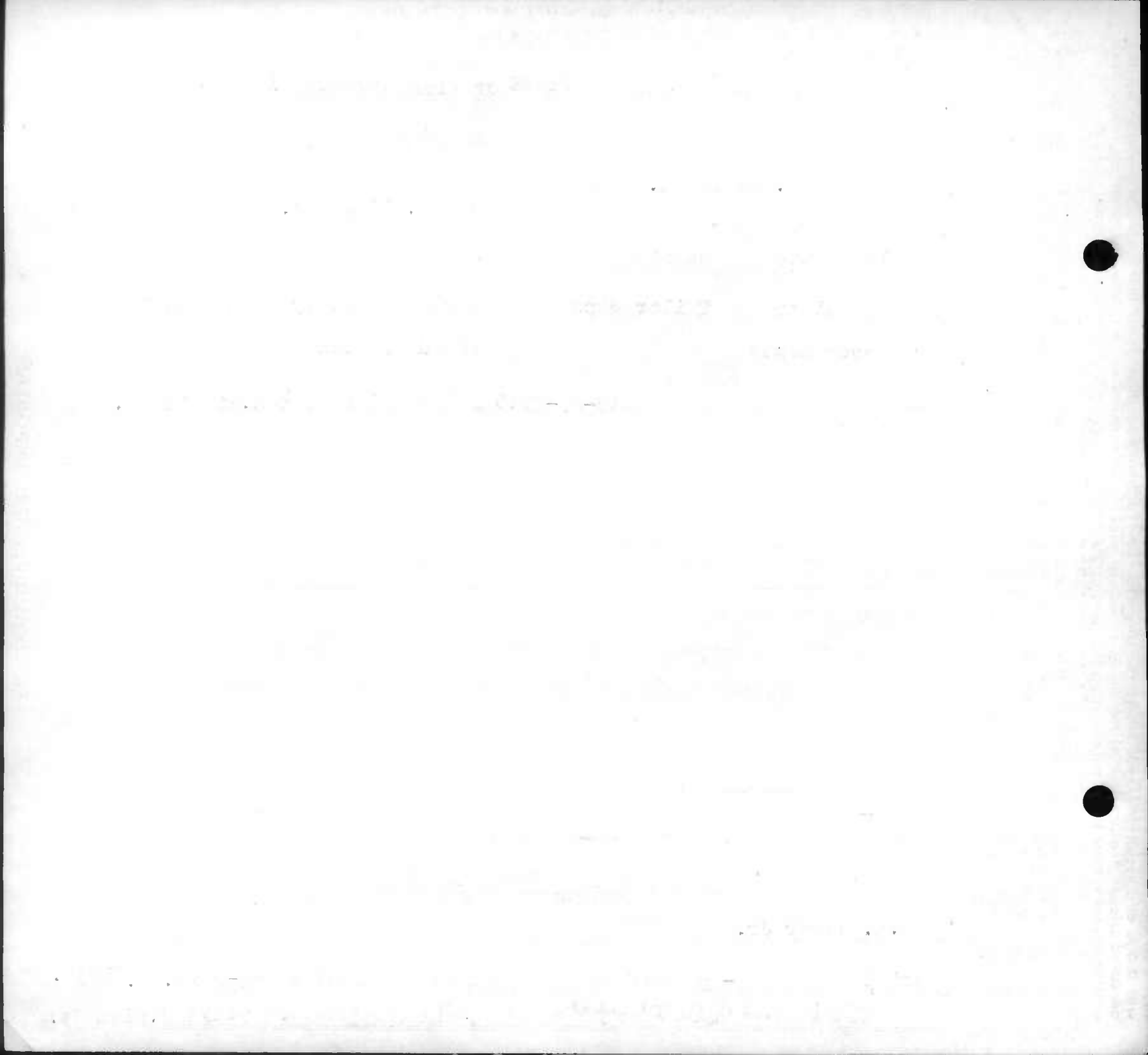
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12650	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 65 12650 CERTIFICATE OF DEATH </div>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) James F. Kemler			2. DATE AND HOUR OF DEATH 12/9/65 7:45 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 36 Franklin Square			A. STATE Maryland B. COUNTY 26-03		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 3017 Kenyon Ave.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 10/12/97	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MUSICIAN		10B. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) MARYLAND Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Kemler			14. MOTHER'S MAIDEN NAME Theresa White		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219 05 1528	17. INFORMANT Thomas Kemler ADDRESS 1637 Chelton Ave Balto		
18. 155.0 I			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO Carcinoma of esophagus with gen. metastases		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/11/65 19 to 12/9/65 19, that (I) (we) last saw the deceased alive on 12/9/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Silvino B. Munese M.D.				23B. DATE SIGNED 12/10/65	
23C. PHYSICIAN'S NAME (Type) Silvino B. Munese M.D.				23D. ADDRESS 101 Calhoun St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/13/65		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn	
				24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR Robert E. Feltz		25C. FUNERAL DIRECTOR Henry Sander & Sons Inc. Balto. Md.	

Continued from p. 1
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12651	
BIRTH NO. 65 12651		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ALEXNDRINA FIORE or Fiore		2. DATE AND HOUR OF DEATH December 10 1965	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 10-01	
609 E.Biddle St.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 609 E.Biddle St.	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH July 11 1890	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Basting puller		10B. KIND OF BUSINESS OR INDUSTRY Tailor Shop		11. BIRTHPLACE (State or foreign country) Tortoreto Italy	
12. CITIZEN OF WHAT COUNTRY? Italy		13. FATHER'S NAME Francesco Leste		14. MOTHER'S MAIDEN NAME Pasqua Fortuna	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 219-03-2010		17. INFORMANT Emidio Fiore ADDRESS 609 E.Biddle St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Arteriosclerotic Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH 15 YRS.	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) DUE TO		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED (While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>)		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the deceased) attended the deceased from Dec 3 1965 to Dec. 10 1965 , that (I) (we) last saw the deceased alive on Dec. 3 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (do) (did not) view the body after death.					
23A. SIGNATURE Wm. H. Kammer Jr.		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11 Dec. 1965	
23C. PHYSICIAN'S NAME (Type) Wm. H. Kammer Jr.		23D. ADDRESS (M.D.) 6011 York Rd. Balt. Md. 21212			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/14-65		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park	
24D. LOCATION (City, town, or county) Taylor Ave-Balt. Md		24E. STATE 21234			
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR John E. Starn, M.D.		25C. FUNERAL DIRECTOR Frank Deller ADDRESS 322 S. High St.	



CERTIFICATE OF DEATH

Registered No. 65 12652

BIRTH NO.

65 12652

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

George Hasbeler

2. DATE AND HOUR OF DEATH

12-10-65 1 PM

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

4009 OVERLEA AVENUE

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

NEVER MARRIED

8. DATE OF BIRTH

3/11/92

9. AGE (In years
last birthday)

73

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

General Maintenance

10B. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

MARYLAND Baltimore

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Anthony J. Hasbeler

14. MOTHER'S MAIDEN NAME

Carrie Gettermann

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

220-07-4680

17. INFORMANT

ADDRESS

RECORDS: BCH - 4940 EASTERN AVE. #21224

18.

420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) DUE TO

Cardio-Respiratory
Failure

10 hrs

(B) DUE TO

myocardial infarct

20 hrs

(C) DUE TO

arterio-sclerosis

1 year

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-9-65 to 12-10-65,
that (I) (we) last saw the deceased alive on 12-10-65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

John R. Burton

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

12-10-65

23C. PHYSICIANS
NAME (Type)

JOHN R. BURTON

M.D.

23D. ADDRESS

BALTO. CITY Hosp

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Dec 14 1965 Holy Redeemer Cemetery

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

4430 Belair Rd

Md

25A. DATE RECEIVED BY HEALTH DEPT.

DEC 13 1965

25B. NAME OF REGISTRAR

Robert E. Tullman

25C. FUNERAL DIRECTOR

Dippel Bros Inc 7110 Belair Road

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

George Washington

August 18

to Mr. [illegible]

Washington, D.C.

Dear Sir,

I have the honor to

acknowledge the

receipt of your

letter

of the 10th inst.
and in reply to inform
you that the same
has been forwarded
to the proper
authorities for
their consideration.

Yours
very
respectfully

J. M. [illegible]
[illegible]

37-17-36
JJBALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 12653

BIRTH NO. 65 12653		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) MARY KOTSCHENREUTER		2. DATE AND HOUR OF DEATH 12-11-65 8:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4940 EASTERN AVENUE	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH Oct 16, 1984
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing		10B. KIND OF BUSINESS OR INDUSTRY Clothing	9. AGE (In years last birthday) 81
13. FATHER'S NAME Andrew Kotschenreuter		11. BIRTHPLACE (State or foreign country) MARYLAND, Baltimore	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. 212-01-9374		14. MOTHER'S MAIDEN NAME Antoinette Schinanowski	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) INTERVAL BETWEEN ONSET AND DEATH Myocardial Infarction 2 hours Generally 1 Anterior wall Year		17. INFORMANT RECORDS: BCH 4940 EASTERN AVENUE #21224 Joan Buresch 3714 Mt. Pleasant Ave Balto	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (If (this hospital) attended the deceased from 4-29-1963 to 12-11-1965, that (We) last saw the deceased alive on 12-11-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (did not) view the body after death.			
23A. SIGNATURE DR. JOHN R. BURTON		23B. DATE SIGNED 12-11-65	
23C. PHYSICIAN'S NAME (Type) DR. JOHN R. BURTON		23D. ADDRESS 4940 EASTERN AVENUE #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/15/65	
24C. NAME OF CEMETERY or CREMATORY Sacred Heart Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR R. E. F. J. M. A.	
25C. FUNERAL DIRECTOR The Dippel, Brothers Inc 1800 E. Lombard St		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 12654		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 12654	
1. NAME OF DECEASED (Type or Print) <i>Mattie Hardaway</i>				2. DATE AND HOUR OF DEATH <i>Dec. 11, 1965 11:30 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Sinai Hospital</i> 12-16-65				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>28-02</i>			
5. SEX <i>Female</i>				6. RACE <i>Colored</i>			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>				8. DATE OF BIRTH <i>Feb. 25, 1891</i>			
9. AGE (In years last birthday) <i>74 yrs.</i>				10. AGE (In years last birthday) <i>74 yrs.</i>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>			
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>				12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Joseph De Haven</i>				14. MOTHER'S MAIDEN NAME <i>Martha Foster</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <i>Mrs. Dorothy Brown</i>				18. ADDRESS <i>2906 Findall Road</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>451X I</i> CAUSE OF DEATH (A) <i>Possible Rupture Abdominal Aneurysm</i> DUE TO				INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs.</i>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>HAS CVD & gen'lized debility at least 15 mos.</i> <i>gen'lized Arteriosclerosis</i> DUE TO <i>unknown</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>8/22</i> 19 <i>65</i> to <i>12/11</i> 19 <i>65</i> , that (I) (we) lost saw the deceased alive on <i>12/11</i> 19 <i>65</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Elijah Saunders</i> M.D.				23B. DATE SIGNED <i>12/13/65</i>			
23C. PHYSICIAN'S NAME (Type) <i>Elijah Saunders</i> M.D.				23D. ADDRESS <i>3414 Duval Ave. Balt 21216 MD</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/15/65</i>		24C. NAME OF CEMETERY OR CREMATORY <i>High Rock</i>		24D. LOCATION (City, town, or county) (State) <i>Rice, Va</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 13 1965</i>		25B. NAME OF REGISTRAR <i>John E. Smith</i>		25C. FUNERAL DIRECTOR <i>Robert Smith</i>		25D. ADDRESS <i>1000 Hill Ave.</i>	

V.S. 153

12-16-65

M.H.

BIRTH NO. 65 12655

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65 12655 Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARY

F.

GRAHAM

2. DATE AND HOUR PRONOUNCED DEAD

December 8, 1965

10:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

413 N. Calhoun Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug 21, 1924

9. AGE (in years
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Seamstress

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George Sutton

14. MOTHER'S MAIDEN NAME

Mattie Baldwin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Johnny Graham 413 N. Calhoun Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Multiple Traumatic Injuries.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Calhoun and Mulberry Streets

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12 8 '65 P. M.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/9/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/12/65

23C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Park

23D. LOCATION

(City, town, or county)

(State)

Balto., Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 13 1965

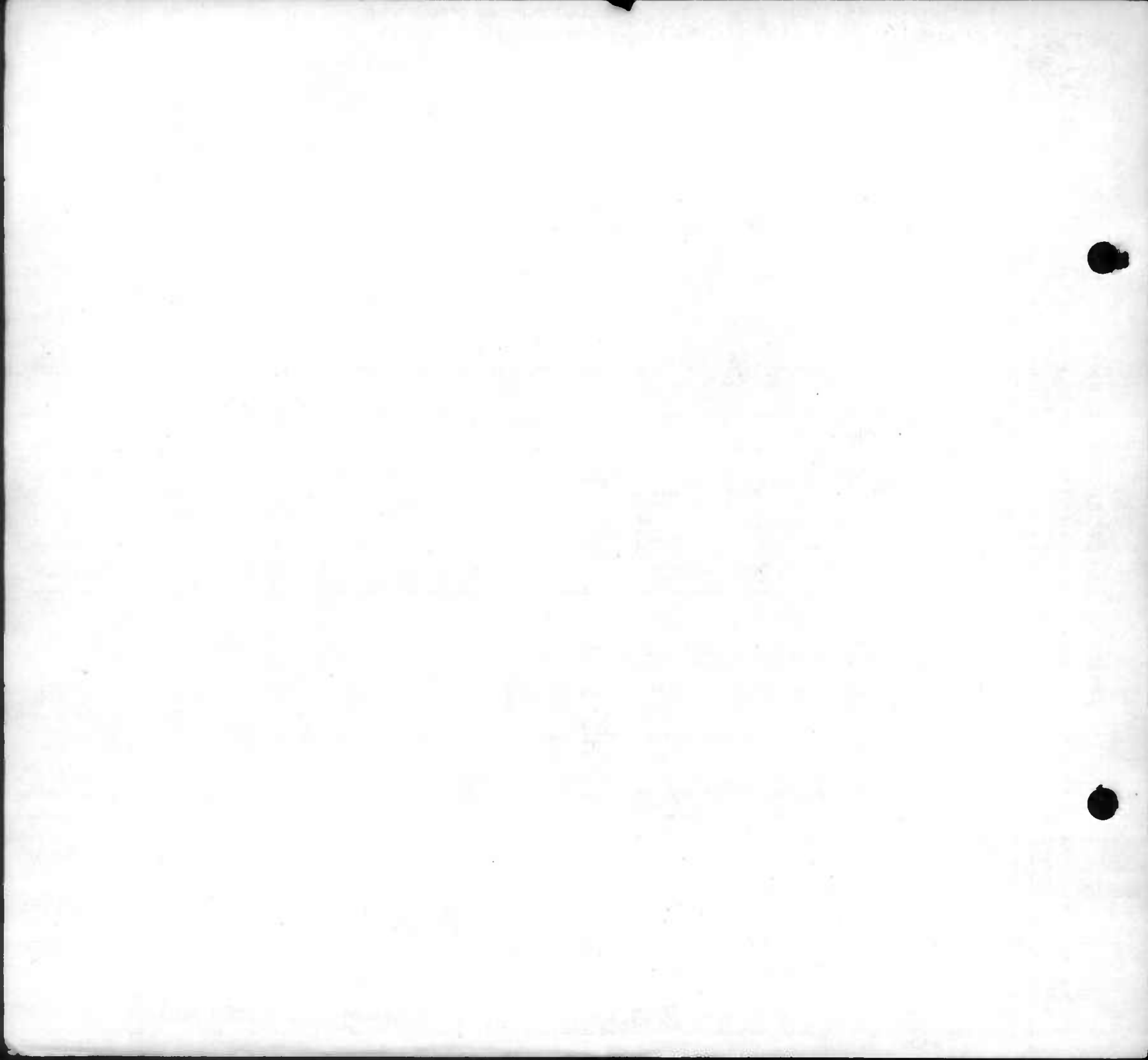
928 E. North Ave.

WALTER
© 1954
P. 15

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

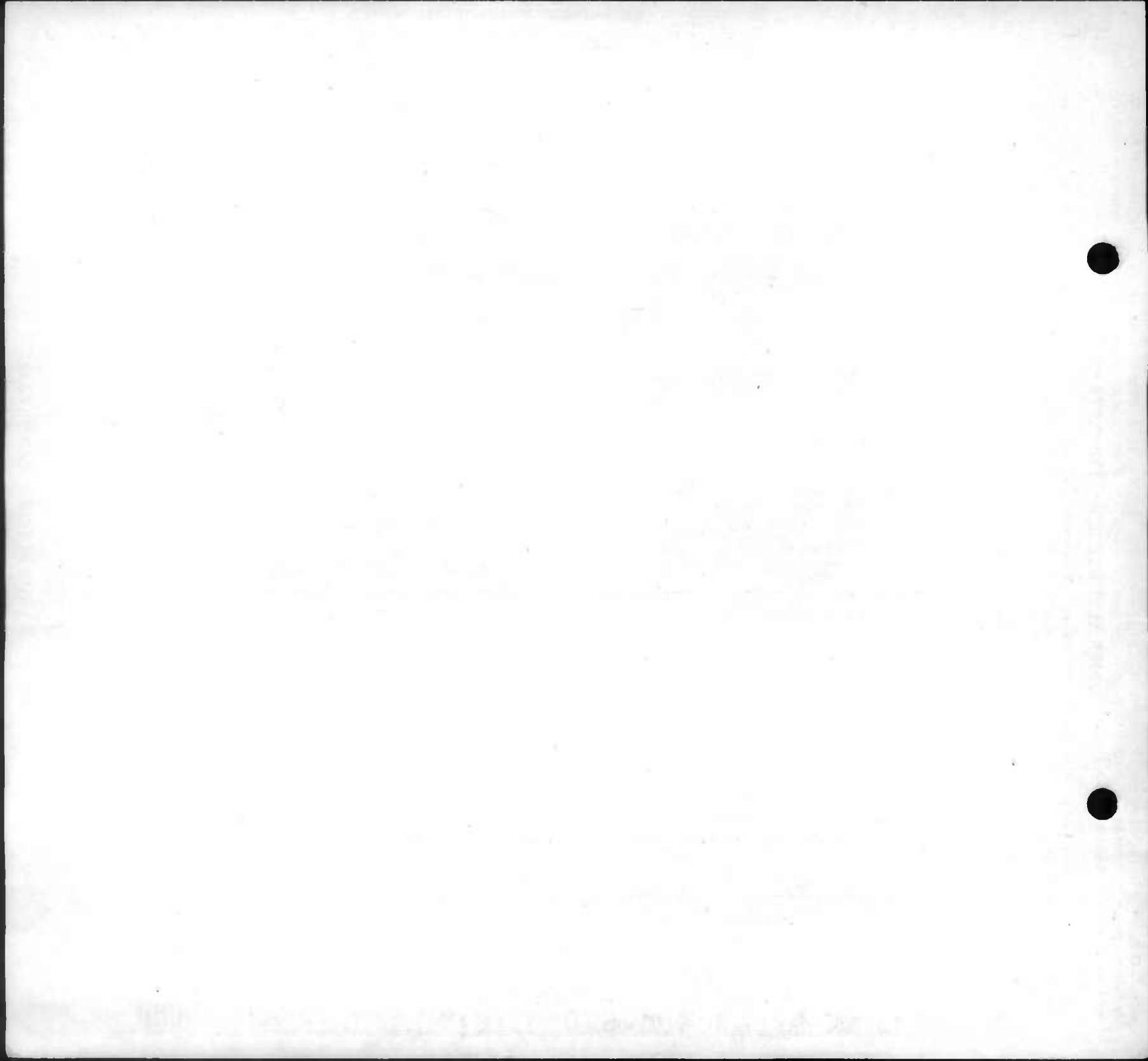
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>65 12656</u>	
BIRTH NO. <u>65-3043 65 12656</u>							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <u>BABY BOB DIGGS.</u>				2. DATE AND HOUR OF DEATH <u>12-2-65 2:48 AM</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSPITAL.</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>MD.</u>		B. COUNTY <u>17-1</u>	
5. SEX <u>M</u>				6. RACE <u>NEGRO</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>DIGGS, ELAINE</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>MOTHER</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>776X I</u> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) <u>PREMATURITY</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
(C) DUE TO							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>12-2-65</u> 19 <u>65</u> to <u>12-2-65</u> 19 <u>65</u> , that (1) (we) last saw the deceased alive on <u>12-2-65</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>						23B. DATE SIGNED <u>12-2-65</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <u>UNIVERSITY HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>DEC 9 1965</u>		24C. NAME OF CEMETERY <u>ANATOMY BOARD OF MARYLAND</u>		24D. LOCATION (City, town, or county) (State) <u>UNIVERSITY MEDICAL SCHOOL</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1965</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

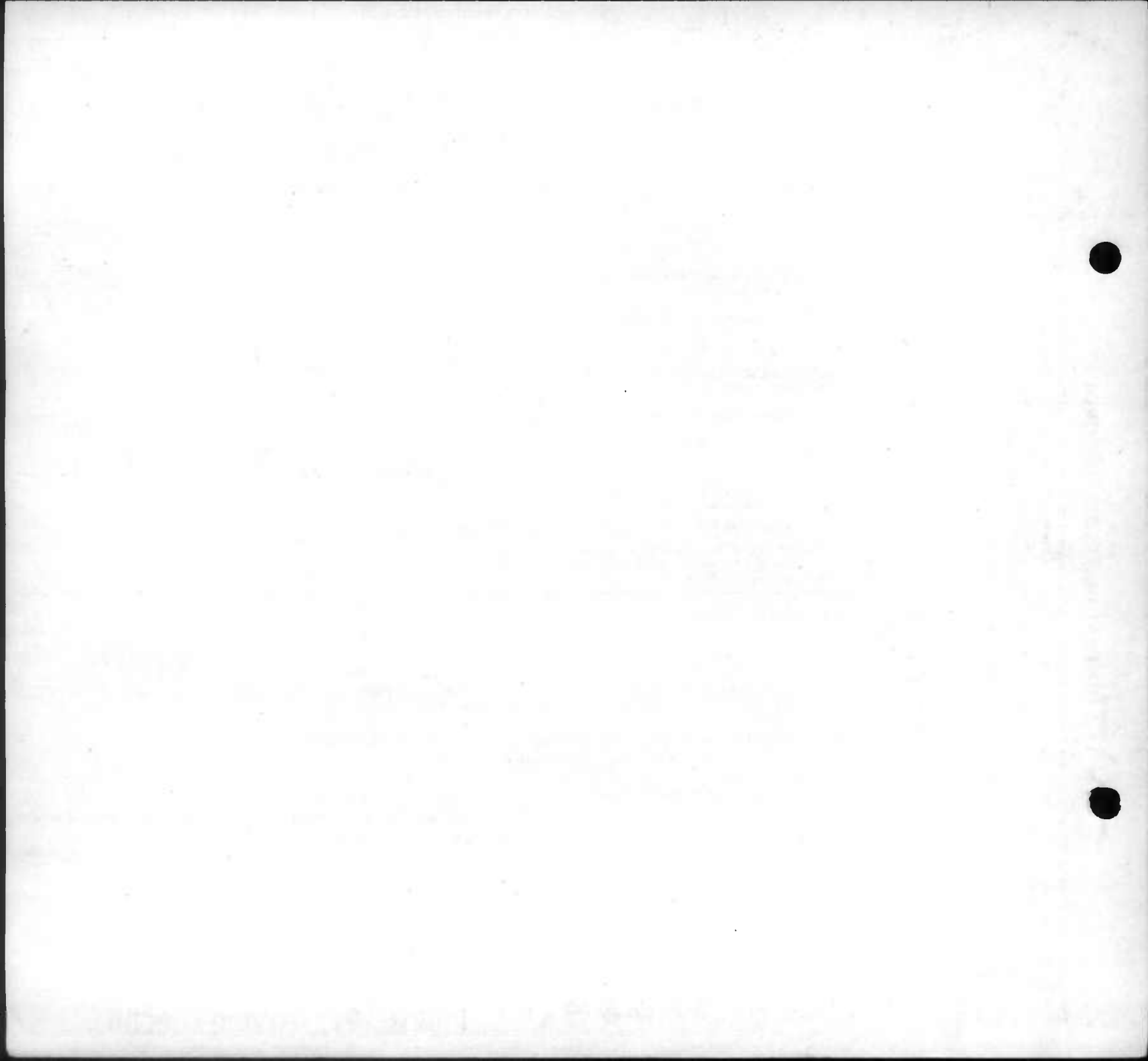
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. <u>65-32594</u> <u>65 12657</u> CERTIFICATE OF DEATH					Registered No. <u>65 12657</u>				
1. NAME OF DECEASED (Type or Print) <u>MACKLIN, BABY Boy</u>					2. DATE AND HOUR OF DEATH <u>12-4-65</u> <u>6</u> ⁵⁰ P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIVERSITY HOSPITAL</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>BALTIMORE</u> B. COUNTY <u>MARYLAND</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>22-2</u> D. STREET ADDRESS (If rural, give location) <u>2212 PERRY ST.</u>				
5. SEX <u>M</u>	6. RACE <u>C</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>12-4-65</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>JOHN ROBERTS</u>					14. MOTHER'S MAIDEN NAME <u>MARION NEWSON</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>-</u>			16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>PATIENT'S MOTHER</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>762.51</u> <u>CAUSE OF DEATH</u>					INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>					(A) <u>Protein</u> DUE TO <u>Immaturity</u> (B) <u>Respiratory</u> DUE TO <u>Aspiration</u> (C) <u>Aspiration</u>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>2</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>12/4</u> 19 <u>65</u> to <u>12/4</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12/4</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>John Roberts</u> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12/4/65</u>		
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>DEC 9 1965</u>		24C. NAME OF CEMETERY OR CREMATORY <u>UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD</u>		24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1965</u>		25B. NAME OF REGISTRAR <u>John Roberts</u>		25C. ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

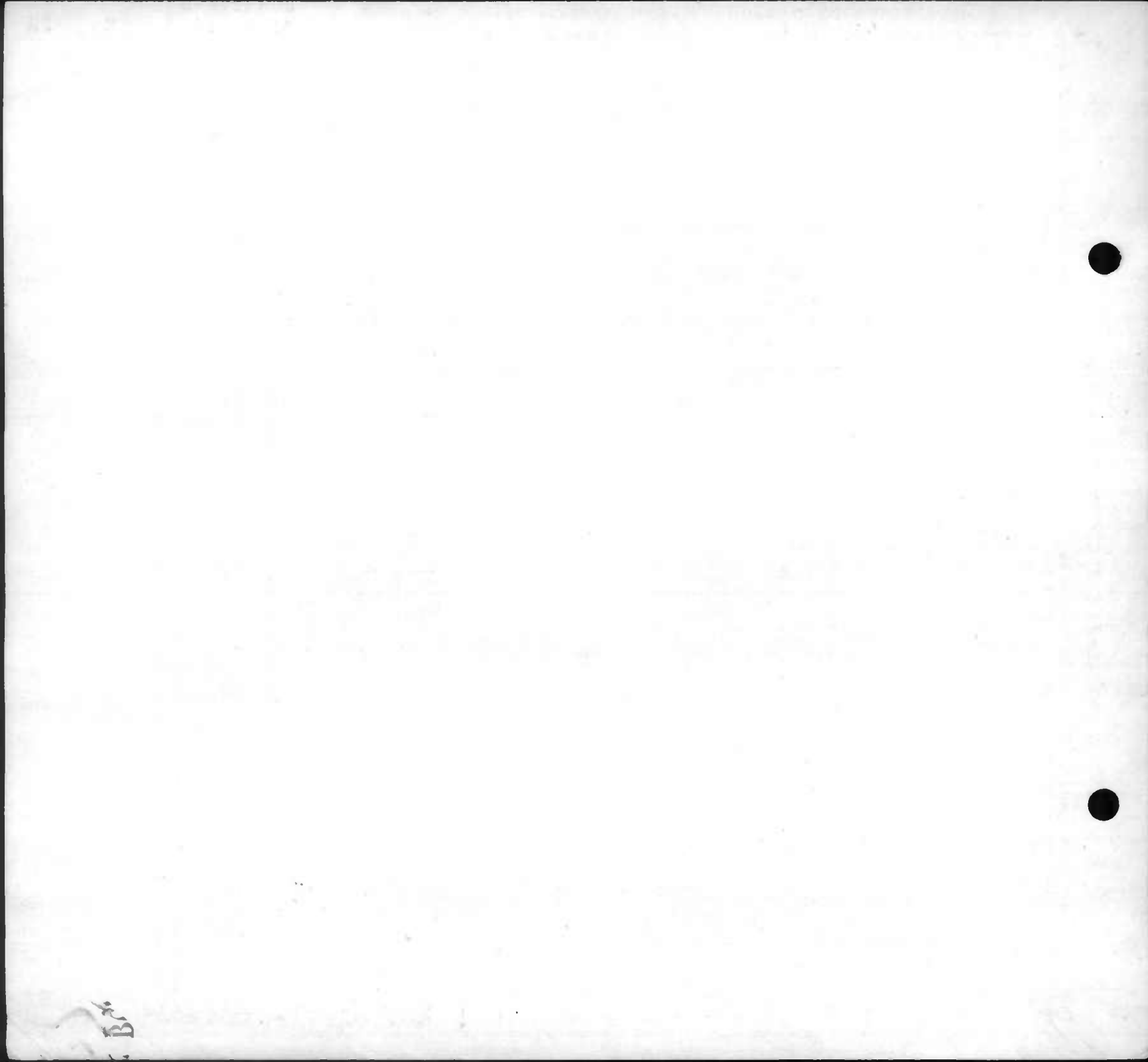
BIRTH NO. 65 30416 65 12658				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12658	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <u>Curtis, Baby girl.</u>			
2. DATE AND HOUR OF DEATH <u>12/3/65</u> <u>1:30</u> <u>PM</u>				3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University of Md Hosp.</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>2308 Nevada St</u>			
5. SEX <u>F</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>never married</u>	8. DATE OF BIRTH <u>12/2/65</u>	9. AGE (In years last birthday) <u>2</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Paul R. Curtis</u>			14. MOTHER'S MAIDEN NAME <u>Gertrude Tate</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>none</u>			17. INFORMANT <u>chart</u>		ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) <u>Immaturity</u>		INTERVAL BETWEEN ONSET AND DEATH <u>life</u>	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)				(B) <u>—</u>		(C) <u>—</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>12/2/65</u> to <u>12/3/65</u> that (I) (<u>we</u>) last saw the deceased alive on <u>12/3/65</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (<u>did</u>) (<u>did not</u>) view the body after death.							
23A. SIGNATURE <u>Mitchell</u>				23B. DATE SIGNED <u>12/3/65</u>			
23C. PHYSICIAN'S NAME (Type) <u>Univ. of Md Hosp.</u>				23D. ADDRESS <u>Univ. of Md Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>DEC 9 1965</u>		24B. DATE		24C. NAME OF CEMETERY or CREMATORY <u>ANATOMY BOARD OF MARYLAND</u>		24D. LOCATION (City, town, or locality) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1965</u>		25B. NAME OF REGISTRAR <u>R. E. Johnson</u>		25C. FUNERAL DIRECTOR <u>UNIVERSITY MEDICAL SCHOOL</u>		ADDRESS <u>MORTUARY SERVICE - BCHD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

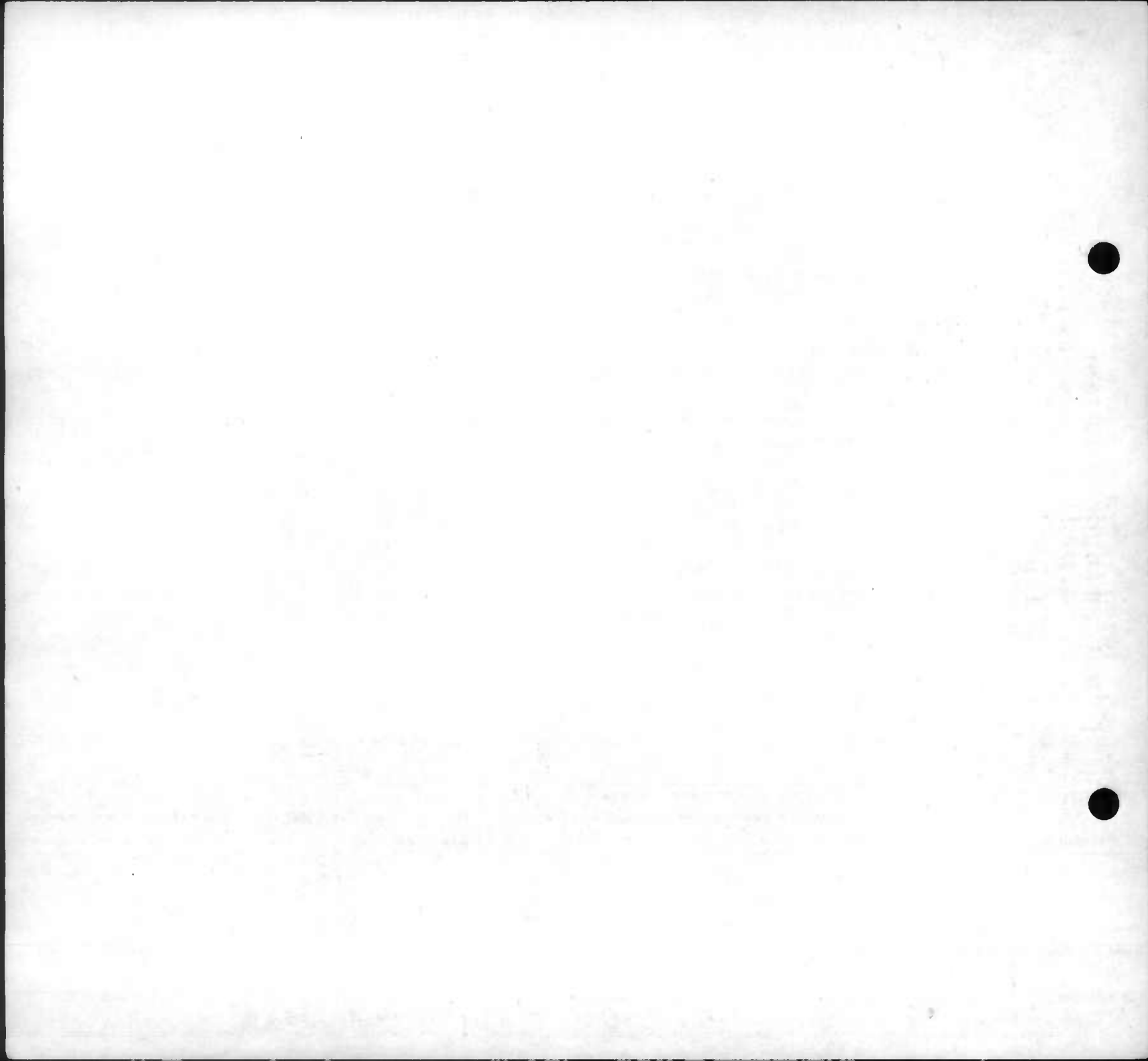
BALTIMORE CITY HEALTH DEPARTMENT									
JUANITA-M 31-93-13 12659 ✓ PN									
BIRTH NO. 65-29298		65 12659		CERTIFICATE OF DEATH			Registered No. 65 12659		
1. NAME OF DECEASED (Type or Print) NICHOLS, Baby Boy				2. DATE AND HOUR OF DEATH 11-24-65 3:05 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION Univ. of Md.				A. STATE Maryland B. COUNTY 14-02					
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					
				D. STREET ADDRESS (If rural, give location) 624 Smithson St #17					
5. SEX M	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) never married		8. DATE OF BIRTH 11/19/65	9. AGE (In years last birthday) 9	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child		10B. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME Frank Austin				14. MOTHER'S MAIDEN NAME Juanita Nichols					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT mother		ADDRESS above	
18. 376 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Immaturity				CAUSE OF DEATH (A) DUE TO Immaturity				INTERVAL BETWEEN ONSET AND DEATH Life -	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(B) DUE TO					
(C) DUE TO									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 0		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 11/19/65 19 to 11/24/65 19, that (I) (we) last saw the deceased alive on 11/24/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Mitchell				23B. DATE SIGNED 11/24/65					
23C. PHYSICIAN'S NAME (Type) M.D.				23D. ADDRESS ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL					
24A. BURIAL CREMATION, REMOVAL (Specify) DEC 9 1965		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR MORTUARY SERVICE		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

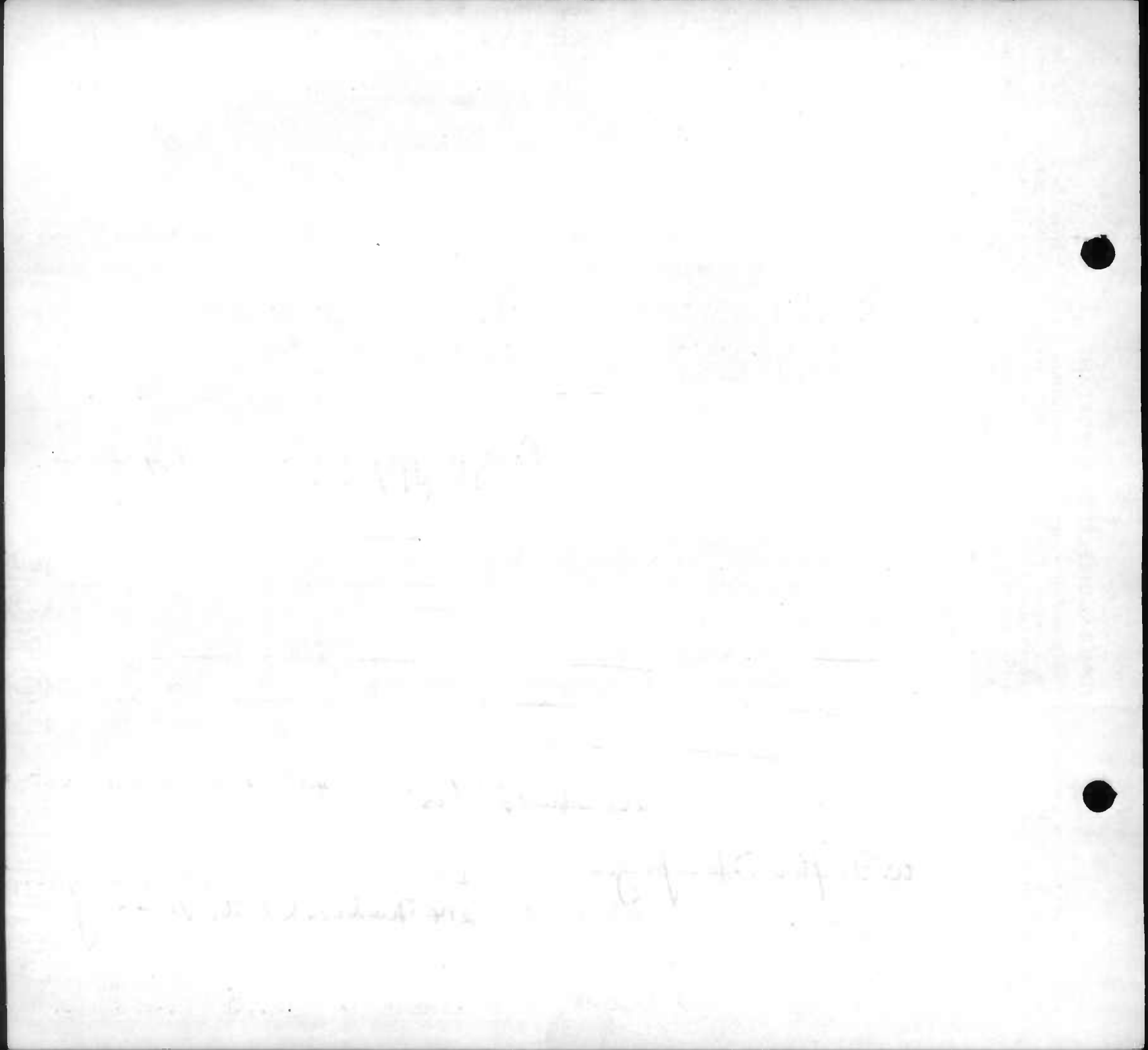
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12660	
BIRTH NO. 65, 29318		65 12660		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Baby Boy MALONE		2. DATE AND HOUR OF DEATH 11-27-65 12:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 14-02		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL		D. STREET ADDRESS (If rural, give location) 1410 Argyle Ave.			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) -	8. DATE OF BIRTH 11-21-65	9. AGE (in years last birthday) 5	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JAMES GARRISON		14. MOTHER'S MAIDEN NAME CATHERINE MALONE		12. CITIZEN OF WHAT COUNTRY? USA.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. -		17. INFORMANT ADDRESS CHART -	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 776X1 (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO PREMATUREITY		INTERVAL BETWEEN ONSET AND DEATH 5 days.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) -		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) No	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from 11-21-65 19 to 11-27-65 19, that (I) (we) last saw the deceased alive on 11-27-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Carlos Abel		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11-27-65	
23C. PHYSICIAN'S NAME (Type) CARLOS ABEL		23D. ADDRESS UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) DEC 9 1965		24B. DATE		24C. NAME of CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR Robert E. Stagnaro		25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE BCHD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 12661</u>	
BIRTH NO. <u>65 12661</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>WILLIAM POPPLEIN HALL, JR.</u>		2. DATE AND HOUR OF DEATH <u>Dec. 11, 1965</u> <u>4:40 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>14-01</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>City of Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Home: 1713 Park Avenue</u>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <u>1713 Park Avenue</u>	
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED <u>Married</u>	8. DATE OF BIRTH <u>Apr. 3, 1901</u>	9. AGE (in years last birthday) <u>64</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Mfg. Agent</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>- Heating Equip.</u>		11. BIRTHPLACE (State or foreign country) <u>St. Michael's, Md.</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>William P. Hall</u>		14. MOTHER'S MAIDEN NAME <u>Amie Dryden</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-07-2013</u>		17. INFORMANT: <u>Wife</u> <u>Mary Hamilton B. Hall, 1713 Park Av., City</u> ADDRESS <u>21217</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>420.1 I</u> <u>Coronary Sclerotic Heart Disease</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>2 3/4 years</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 1</u> 19 <u>45</u> to <u>December 11</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>December 6</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>W. Grafton Hersperger</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>December 12, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>W. GRAFTON HERSPERGER</u>		23D. ADDRESS <u>214 Medical Arts Building</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>12/14/65</u>		24C. NAME of CEMETERY or CREMATORY <u>Green Mount Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1965</u>		25B. NAME OF REGISTRAR <u>R. E. F. J. J.</u>		25C. FUNERAL DIRECTOR <u>Stewart & Mowen Co., 108 W. North Av., City</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 12662				
BIRTH NO. 65 12662					M.E. CASE NO. 65 12662				
1. NAME OF DECEASED (Type or Print) Mrs. ANNA Groeninger					2. DATE AND HOUR OF DEATH 12.8.1965-1615 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) A. STATE Maryland B. COUNTY Queen Anne's				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 34 Bon Secours Hospital					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Stevensville				
					D. STREET ADDRESS (If rural, give location) Route 1 Box 43A				
5. SEX Fe	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8/20/1904	9. AGE (In years last birthday) 61	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist			10B. KIND OF BUSINESS OR INDUSTRY Flower shop.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Anthony Hilscher					14. MOTHER'S MAIDEN NAME Sophie				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 216-01-6474		17. INFORMANT Nisp Records				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION CAUSING IT. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) Cerebral Vascular accident (clot) (B) Hypertension (C) Arteriosclerosis				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 12.7.1965 to 12.8.1965, that (I) (we) last saw the deceased alive on 12.7.1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE M. Bodner					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12.8.1965		
23C. PHYSICIAN'S NAME (Type) M. Bodner					23D. ADDRESS M.D.				
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial			24B. DATE 12-10-65		24C. NAME of CEMETERY or CREMATORY NEW CATHEDRAL LEM		24D. LOCATION (City, town, or county) (State) BALTO MD		
25A. DATE RECD BY HEALTH DEPT. DEC 13 1965					25B. NAME OF REGISTRAR J. F. Evans		25C. FUNERAL DIRECTOR J. F. Evans		
					ADDRESS 8802 HARTFORD Rd				

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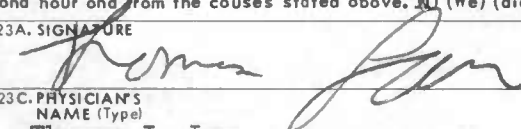
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																								
BIRTH NO. 65 12663					CERTIFICATE OF DEATH					Registered No. 65 12663														
1. NAME OF DECEASED (Type or Print) CASTANEDA, Eulalio Vipinosa					2. DATE AND HOUR OF DEATH Dec-8-1965 9:00 PM 9:00 P.M.																			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Balto																			
FULL NAME OF HOSPITAL OR INSTITUTION U. S. Public Health Service Hospital 31st Street & Wyman Park Drive Baltimore, Maryland					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					D. STREET ADDRESS (If rural, give location) 3516 E. Joppa Road														
5. SEX Male		6. RACE Cau		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH Feb-12-1900		9. AGE (In years last birthday) 65		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.												
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steward					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Philippine Islands					12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Higina Castaneda					14. MOTHER'S MAIDEN NAME Francisca Vipinosa																			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 132-05-5600					17. INFORMANT Records-USPHS Hospital, Baltimore, Md.					ADDRESS									
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction (A) DUE TO Atherosclerosis, generalized (B) DUE TO (C) DUE TO										INTERVAL BETWEEN ONSET AND DEATH Hours Years														
															ANTECEDENT CAUSES									
															DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
															II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Benign Prostatic Hypertrophy									
19A. DATE OF OPERATION 2					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) Yes					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)														
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?														
22. I certify that He (this hospital) attended the deceased from Nov. 5 19 65 to Dec. 8 19 65 , that we last saw the deceased alive on Dec. 8 19 65 and that in My (our) opinion death occurred on the date and hour and from the causes stated above. We (did) not view the body after death.																								
23A. SIGNATURE 										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED Dec. 9, 1965									
23C. PHYSICIAN'S NAME (Type) Thomas J. Lau										23D. ADDRESS M.D. USPHS Hospital, Baltimore, Md.														
24A. EMERAL CEMETERY REMOVAL (specify)					24B. DATE 12/11/65					24C. NAME OF CEMETERY OR CREMATORY GREENMOUNT					24D. LOCATION (City, town, or county) (State) BALTO Md									
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965					25B. NAME OF REGISTRAR Chas F. Evans & Son					25C. FUNERAL DIRECTOR 8802 Hagerford					ADDRESS									

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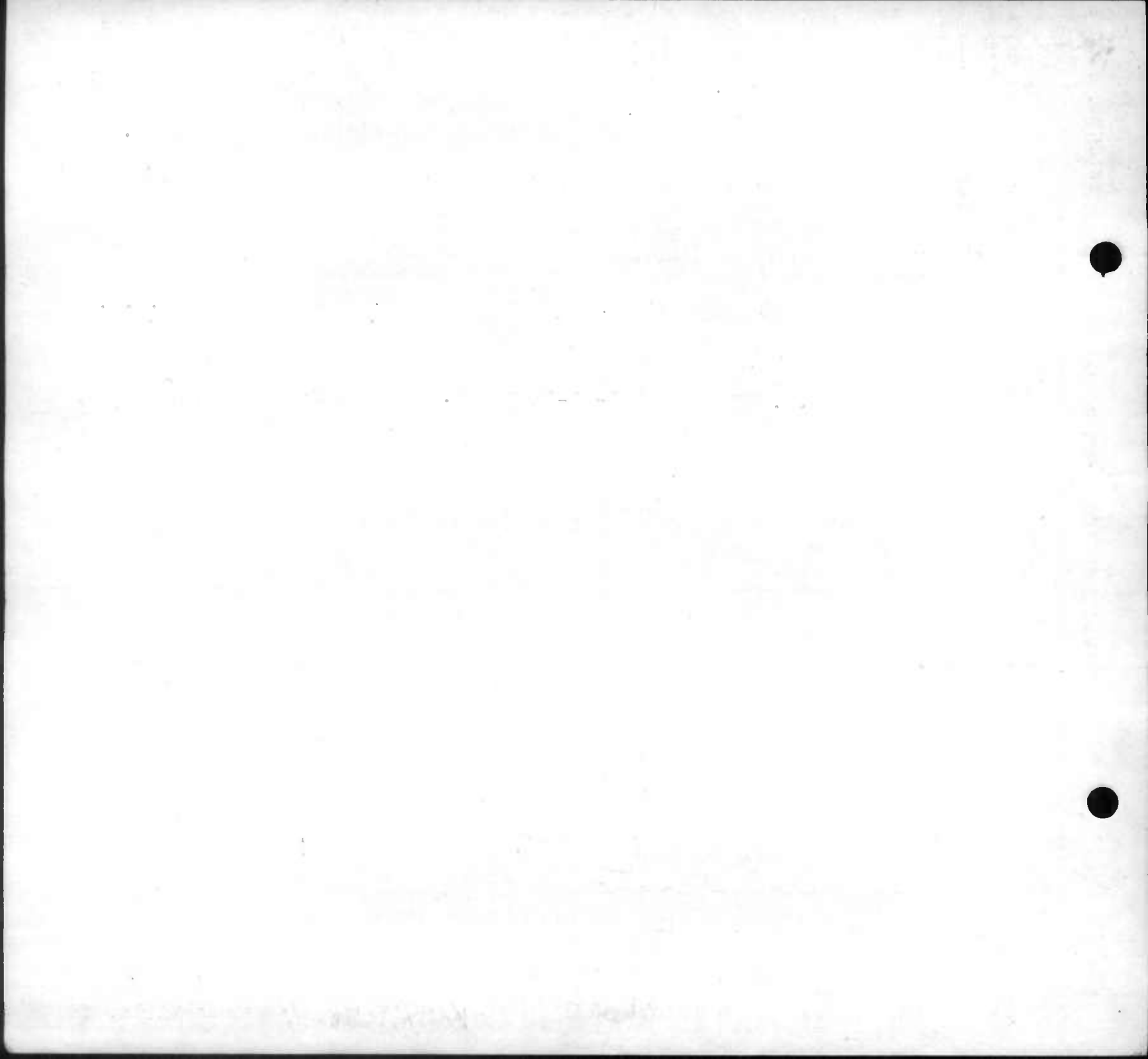
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 12664					CERTIFICATE OF DEATH					Registered No. 65 12664				
1. NAME OF DECEASED (Type or Print) JOHN L. RITCHEY					2. DATE AND HOUR OF DEATH 12/10/65 1:50 A.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY PENNSYLVANIA Franklin Co.									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL					C. CITY OR TOWN (If outside city limits, write RURAL and give township) MERCERBURG					D. STREET ADDRESS (If rural, give location) ROUTE #2				
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 6-18-09		9. AGE (In years last birthday) 56		10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent					10B. KIND OF BUSINESS OR INDUSTRY General Insurance					11. BIRTHPLACE (State or foreign country) Pennsylvania				
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME RICHARD B. RITCHEY					14. MOTHER'S MAIDEN NAME MARY LOUISE BROWN				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W. II					16. SOCIAL SECURITY NO. 173-03-3107					17. INFORMANT Mrs. John Ritchey				
					ADDRESS Route #2 Mercersburg, Pa									
18. 5-27-11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Pulmonary emphysema DUE TO (B) Cor pulmonale DUE TO (C)					INTERVAL BETWEEN ONSET AND DEATH 7 years 1 year				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) No				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (X) (this hospital) attended the deceased from 11/7 1965 to 12/10 1965, that (I) (we) last saw the deceased alive on 12/10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE William B. Cutts					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 12/10/65				
23C. PHYSICIAN'S NAME (Type) WILLIAM B. CUTTS					23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL									
24A. BURIAL CREMATION, REMOVAL (Specify) Removal					24B. DATE Dec 10, 1965					24C. NAME OF CEMETERY or CREMATORY Fairview Cemetery				
24D. LOCATION (City, town, or county) (State) Mercersburg, Pennsylvania														
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965					25B. NAME OF REGISTRAR Robert E. Feltman					25C. FUNERAL DIRECTOR H. J. Eckhardt				
					ADDRESS Owings Mills, Md									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12665				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12665	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) AGNES E. RIGNEY				2. DATE AND HOUR OF DEATH 17-10-65 12:18 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME & HOSPITAL		(If not in hospital or institution, give street address or location) BALTIMORE, Md.		A. STATE MARYLAND		B. COUNTY BALTIMORE	
5. SEX FEMALE				6. RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY Domestic		8. DATE OF BIRTH 12-7-98	
13. FATHER'S NAME JOHN SCHALITSKY				14. MOTHER'S MAIDEN NAME FRANCES STILLING		9. AGE (In years last birthday) 67	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 212-03-70023		11. BIRTHPLACE (State or foreign country) MARYLAND	
17. INFORMANT CHARLES F. RIGNEY				ADDRESS 1502 GALENA ROAD			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 260X I				CAUSE OF DEATH (A) Cerebrovascular Accident		INTERVAL BETWEEN ONSET AND DEATH days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				(B) Arteriosclerosis Mellitus		year	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C)			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12-5-65 to 12-10-65 , that (I) (we) lost saw the deceased alive on 12-10-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Idilia C. Mariado				M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-10-65	
23C. PHYSICIAN'S NAME (Type) IDILIA C. MARIADO				23D. ADDRESS CHURCH HOME & HOSPITAL BALTIMORE, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-14-65		24C. NAME of CEMETERY or CREMATORY London PARK		24D. LOCATION (City, town, or county) (State) BALTIMORE, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME of REGISTRAR Robert E. Sullivan		25C. FUNERAL DIRECTOR GEORGE SCHWAB FUNERAL HOME ADDRESS Martin W. Miller 2101 Radnick Ave.			

John White

John White
Baltimore, Md.

John White

John White

John White

John White

John White

John White

John White

John White

John White

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 12666 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12666

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HERMAN J. TURNER

2. DATE AND HOUR PRONOUNCED DEAD

December 7, 1965

8:35 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1610 Marshall Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1610 Marshall Street

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

3/6/17

9. AGE (In years
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Maintenance

10B. KIND OF BUSINESS OR INDUSTRY

Chemical Co.

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Unk Turner

14. MOTHER'S MAIDEN NAME

Sallie Unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Dorothy Turner, Same as line D

18. 5-8114-002.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Fatty liver
DUE TO acute and chronic alcoholism

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Pulmonary tuberculosis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-8-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION (City, town, or county)

(State)

Burial

12/11/65

Cedar Hill Cemetery

Anne Arundel Co., Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 13 1965

Rudiger Breiteneker, M.D.

McCully Funeral Home 130 E Fort Ave

WALTER FORGE

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65 12667

BALTIMORE CITY HEALTH DEPARTMENT

65 12667

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARY C. HITTEL

~~HITTEL~~

2. DATE AND HOUR PRONOUNCED DEAD

December 9, 1965

3:35 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2701 Wilkens Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

Nov. 1, 1891

9. AGE (In years
last birthday)

74 XX

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

SEAMTRIST

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

FRANK H. HITTEL

14. MOTHER'S MAIDEN NAME

MARGARET E.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

217-22-0343

17. INFORMANT

ADDRESS

MRS. GLADYS M. WEBER 1219 NORTH AVENUE 21227

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive and Arteriosclerotic
Cardiovascular Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/9/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

12/11/65

23C. NAME of CEMETERY or CREMATORY

NEW CATHEDRAL CEMETERY

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE,

MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

DEC 13 1965

24B. NAME OF REGISTRAR

Robert E. Jackson, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

HUBBARD FUNERAL HOME 4107 WILKENS AVE. #29

100-1000

UNITED STATES OF AMERICA

IN SENATE
January 1, 1900

REPORT
OF THE

COMMISSIONER OF THE GENERAL LAND OFFICE
FOR THE YEAR 1899

WASHINGTON
GOVERNMENT PRINTING OFFICE
1900

100-1000

UNITED STATES OF AMERICA

IN SENATE
January 1, 1900

REPORT
OF THE

COMMISSIONER OF THE GENERAL LAND OFFICE
FOR THE YEAR 1899

WASHINGTON
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1900

100-1000

UNITED STATES OF AMERICA

1
J-520

65 12668 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12668

BIRTH NO.
M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) CHARLES A. JAMES, Jr.
2. DATE AND HOUR PRONOUNCED DEAD December 8, 1965 10:35 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) ROAD 63-00
1207 Oakland Terrace XXXX 21227

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
40 St. Agnes Hospital

5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH Jan. XX 25, 1927 9. AGE (In years last birthday) 38
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RATE CLERK
11. BIRTHPLACE (State or foreign country) XXXXXXXXXX MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME CHARLES A. JAMES, SR.
14. MOTHER'S MAIDEN NAME SARAH FOUNTAIN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na arunknwn), (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO. -----
17. INFORMANT ADDRESS 21227
MRS. DOROTHY O. JAMES, 1207 OAKLAND TERRACE RD.

18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Carbon Monoxide Intoxication.
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) State Park 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 53-00 Patapsco State Park (River Road) Balto. Co.
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 12 8 '65 P 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21F. HOW DID INJURY OCCUR? Ran hose from exhaust into auto.

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐
ACTUAL SIGNATURE Charles S. Petty, M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) Charles S. Petty, M.D. M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED 12/9/65

23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 23B. DATE 12/11/65 23C. NAME of CEMETERY or CREMATORY MEADOWRIDGE MEMORIAL PARK 23D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND
24A. DATE REC'D BY HEALTH DEPT. DEC 13 1965 24B. NAME OF REGISTRAR Robert E. Feltman 24C. FUNERAL DIRECTOR ADDRESS HUBBARD FUNERAL HOME 4107 WILKENS AVE. # 29

WALLACE JOHNSON

65 12669

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12669

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES

WILSON

2. DATE AND HOUR PRONOUNCED DEAD

December 10, 1965

4:45 A

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1631 Park Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

9-29-1899

9. AGE (In years
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

JANITOR

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Henry Wilson

14. MOTHER'S MAIDEN NAME

Nancy Perrines

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)

None

16. SOCIAL
SECURITY NO.

218-09-5272

17. INFORMANT

ADDRESS

Mrs. Mary Wilson - 1631 Park Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
12/10/6523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-15-65

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary

23D. LOCATION

(City, town, or county)

A.A. Co.

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 13 1965

24B. NAME OF REGISTRAR

Robert E. Dyett

24C. FUNERAL DIRECTOR

Robert E. Dyett

ADDRESS

1701 Laurens

WALTER EDWARDS

RECEIVED

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12670	
BIRTH NO. 65 12670				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) JOHN ISAAC CAMPBELL			2. DATE AND HOUR OF DEATH 12/11/65 11:00 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL, BALTO., MD.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 609 COLETTE ST. 21217 Collett		
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 3/18/04	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ISAAC CAMPBELL			14. MOTHER'S MAIDEN NAME MARY HARCUM		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-18-4361	17. INFORMANT ADDRESS Wyre W^m Campbell 1814 Clifton Ave.		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury at complication which caused death.) Arteriosclerotic Cardiovascular Disease			CAUSE OF DEATH (A) DUE TO Arteriosclerotic Cardiovascular Disease years		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute Myocardial Infarction			(B) DUE TO Acute Myocardial Infarction 3 wks		
			(C) Renal Failure 2 days		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-25 19 65 to 12-11 19 65 , that (I) (we) last saw the deceased alive on 12-11 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B. Bernard Pleet				23B. DATE SIGNED 12-11-65	
23C. PHYSICIAN'S NAME (Type) Bernard Pleet		23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-18-65		24C. NAME of CEMETERY or CREMATORY MT Auburn	
24D. LOCATION BALTO.		24E. (City, town, or county) (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR R. D. Pleet		25C. FUNERAL DIRECTOR MORTON Dye II	
				ADDRESS 1701 LAURENS	

14-20

Paul J. Lawrence

1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th

BIRTH NO.

65 12671

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 12671

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JASPER

CHARLES

2. DATE AND HOUR PRONOUNCED DEAD

December 10, 1965

3:15 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1827 Hope Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

9-2-1948

9. AGE (In years
last birthday)

17

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Newport News, VA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James A. Charles

14. MOTHER'S MAIDEN NAME

Cleora Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Cleora Charles

1827 Hope St.

18.

E 819.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Craniocerebral Injury.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

Jones Falls Expressway, Baltimore

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12 10 '65 A

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Passenger in auto into fixed object.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/10/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-14-65

23C. NAME of CEMETERY or CREMATORY

BALLO NAT

23D. LOCATION

BALTO.

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 13 1965

24B. NAME OF REGISTRAR

Robert E. Fickman

24C. FUNERAL DIRECTOR

Morton G. Dyett

ADDRESS

1701 Laurens

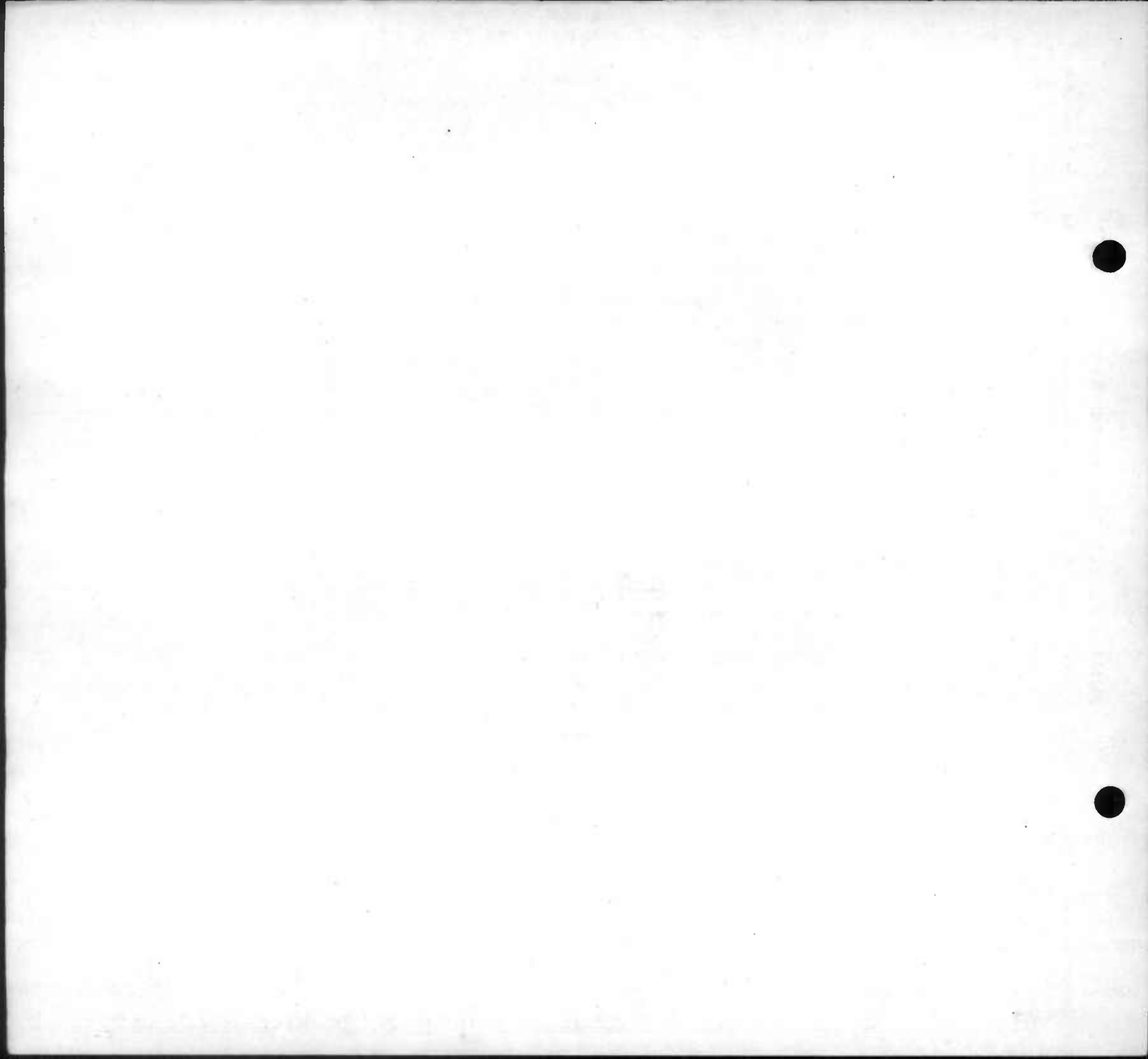
Between

Calvert & H. Paul

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12672				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12672	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ALBERT MATHEWS				2. DATE AND HOUR OF DEATH 12:30 PM 12-12-65 1:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 462 Lutheran Hosp.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 16-08			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 786 Linnard St 20029			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) never married	8. DATE OF BIRTH 5/23/23	9. AGE (In years last birthday) 42 yr.	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10B. KIND OF BUSINESS OR INDUSTRY Golger Ruhl Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Brown				14. MOTHER'S MAIDEN NAME Alice Mathews			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 219-14-1253		17. INFORMANT Kathleen Mathews		ADDRESS 2708 Witherin St. 16 Baltimore	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. C. V. A. hypertension				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12-12-65 19 to 12-12-65 19, that (I) (we) last saw the deceased alive on 12-12-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE F. Abbowsy				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-12-65	
23C. PHYSICIAN'S NAME (Type) Fadhil ABBOWSY				23D. ADDRESS Lutheran Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-16-65		24C. NAME of CEMETERY or CREMATORY BALTO. NAT.		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR MORTON J. Dyer		ADDRESS 1701 Laurens	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 12673		CERTIFICATE OF DEATH		65 12673	
1. NAME OF DECEASED (Type or Print) BERTHA P. ZOLLER			2. DATE AND HOUR OF DEATH 12/11/65 11:45 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 12-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) CAMBRIDGE ARMS APT 4B		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 6/3/76	9. AGE (In years last birthday) 89	10. Under 1 Yr. Months: Days: Hours: Min. 3 Yrs 11 Mo 11 D 11 H 45 M
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY HOME MAKER	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME MR. ANDREW C. GRAY (D)			14. MOTHER'S MAIDEN NAME SOPHIA PINKNEY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. ---	17. INFORMANT NURSE		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) arteriosclerosis Cardiovascular disease with congestive heart failure			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH 3 YRS 11 Mo 11 D 11 H 45 M		
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ---		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) ---	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) ---		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? ---	
22. I certify that (I) (this hospital) attended the deceased from 12/11/65 to 12/11/65 , that (I) (we) last saw the deceased alive on 12/11/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ronald Goldner			23B. DATE SIGNED 12/11/65		
23C. PHYSICIAN'S NAME (Type) Ronald Goldner			23D. ADDRESS Md. General Hospital, Baltimore, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/14/1965		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
24D. LOCATION Baltimore		24E. LOCATION Baltimore		24F. LOCATION Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR H. W. Jenkins & Sons Co.		25C. FUNERAL DIRECTOR ADDRESS 4905 York Road Balto. 12, Md.	

THE NEW YORK PUBLIC LIBRARY

ASTOR LENOX TILDEN FOUNDATION

1215 Broadway New York City

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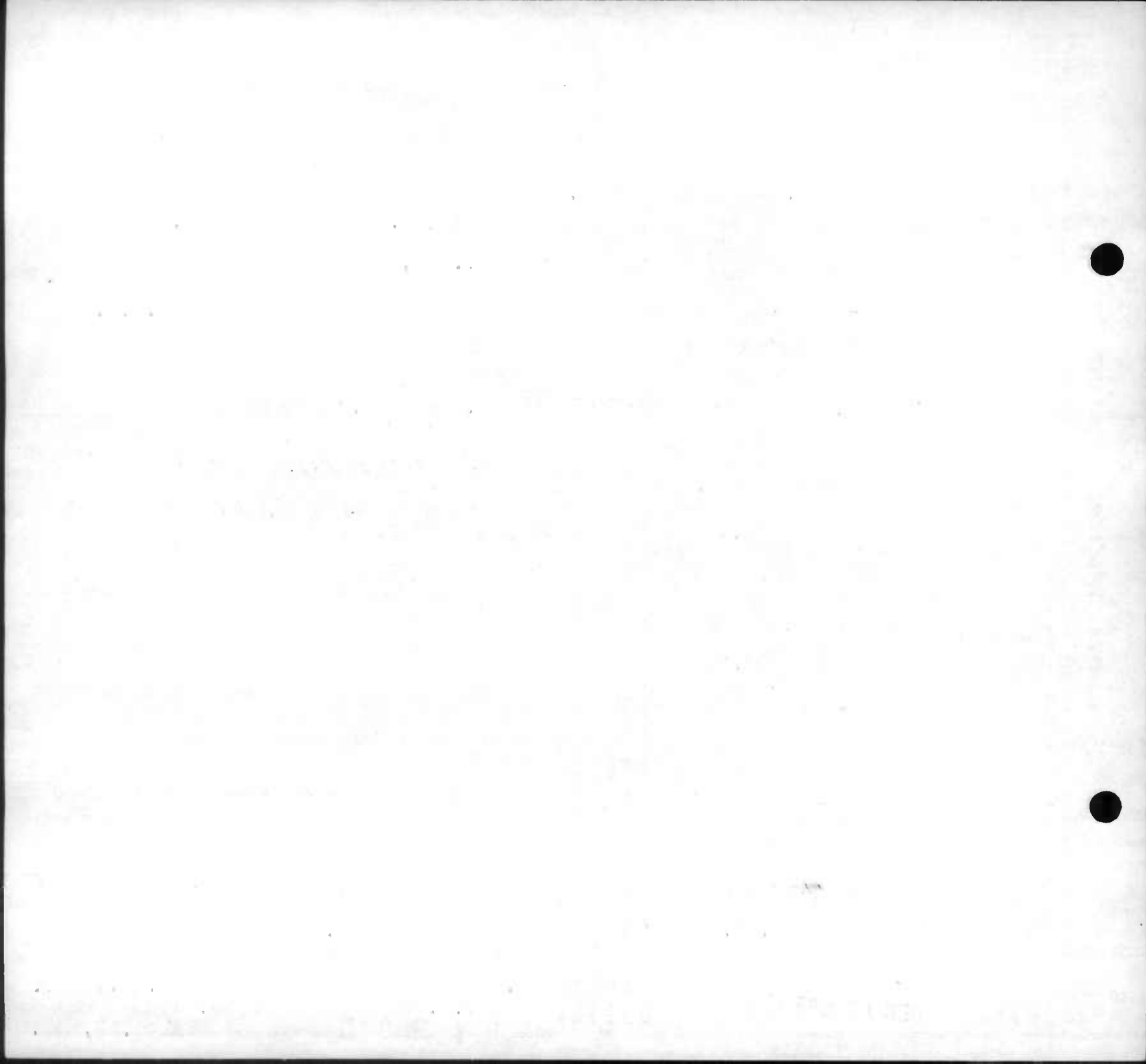
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

65 12674		BALTIMORE CITY HEALTH DEPARTMENT		65 12674	
BIRTH NO.		65 12674		Certificate of Death	
M.E. CASE NO.				Registered No.	
1. NAME OF DECEASED (Type or Print)		Gustav Winckelmann		2. DATE AND HOUR OF DEATH December 10, 1965 10 ³⁰ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		12-21	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
100 W. University Pkwy.		Baltimore		D. STREET ADDRESS (If rural, give location)	
100 W. University Pkwy.		100 W. University Pkwy.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Dec. 19, 1884	9. AGE (In years) 80	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Manager		10B. KIND OF BUSINESS OR INDUSTRY Production		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Heinrick Winckelmann		14. MOTHER'S MAIDEN NAME Margarethe Dammann	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-03-2899		17. INFORMANT Mrs. Lenore E. Winckelmann	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH A. DUE TO B. DUE TO C. DUE TO II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19. DATE OF OPERATION 0		20. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 1955 to Dec 10 th 1965, that (I) (we) last saw the deceased alive on Dec 9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE W. H. Woody		23B. DATE SIGNED 12-13-65	
23C. PHYSICIAN'S NAME (Type) W. H. Woody		23D. ADDRESS 1403 Park Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 12/10/1965		24C. NAME OF CEMETERY OR CREMATORY Lorraine Pk. Mausoleum Woodlawn, Balto. Co., Md.	
24D. LOCATION (City, town, or county) (State) Balto. 12, Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-36265 12675		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12675	
BIRTH NO.		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		LEOPOLD KOTERWAS		12-9-65 1:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4201 PENNINGTON AVENUE		2505	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days
WHITE	MALE	WIDOWED	MAR. 3, 1873	92	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
WATCHMAN		EASTERN BOX CO.		POLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JOSEPH KOTERWAS		FRANCES			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		217-07-8605		FRANK KOTERWAS 3006 111 N. 15 AVE. RECORDS: BCH 4940 EASTERN AVENUE 21227	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
422.1 I		ASCVD		10 yrs	
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) Pneumonia		1 wh	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 10/14/65 to 12/9/65, that (2) (we) last saw the deceased alive on 12/9/65 and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Harry Dean Albert		12/9/65			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
DR. HARRY DEAN ALBERT		4940 EASTERN AVENUE #21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12-13-65		Sacred Heart of Mary Cem.	
				Balt. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 13 1965		Robert E. Johnson		Wm. J. Talkowski	
				2007 Eastern Ave. Balt. Md. 21231	

1875

12-15-65 Secord, Wm. H. & Co. Secord, Wm. H. & Co.
1875

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12676	
BIRTH NO. 65 12676				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) BROWN OTHO L		2. DATE AND HOUR OF DEATH DEC 9 1965 11:30 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE MD B. COUNTY 16-08			
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	
8. DATE OF BIRTH 10-26-04		9. AGE (In years last birthday) 61		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUILDING ESTIMATOR		10B. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (State or foreign country) N.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM HENRY H.		14. MOTHER'S MAIDEN NAME REBECCA CRAVEN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 237-48-9285		17. INFORMANT ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Pyelonephritis & Dehydration and Renal Failure.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 12-1-1965 12-9-1965	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from DEC 8 1965 to DEC 9 1965 , that (I) (we) last saw the deceased alive on DEC 9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE CARL MATTHEY		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-9-65	
23C. PHYSICIAN'S NAME (Type) Carl Matthey		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-13-65		24C. NAME OF CEMETERY or CREMATORY Pleasant Grove Cem.	
24D. LOCATION (City, town, or county) (State) Wilkes County N.C.					
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR Robert E. Fadden		25C. FUNERAL DIRECTOR ADDRESS W. Fialkowski 2007 Eastern Ave. Balt. Md. 21231	

337-48-1482

NO

CRABEN

Building Construction

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21227

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Bureau 11-13-12 Pleasant River Can
Wickham County N.C.
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M-252

65 12677

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12677

BIRTH NO. M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
MARY MCKENZIE		December 8, 1965 2:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital		A. STATE Maryland B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
		Baltimore	
		D. STREET ADDRESS (If rural, give location)	
		1721 Gwynns Falls Parkway	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
Female	Negro	Married	Sept. 5, 1905
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday)
			60
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Baltimore, Maryland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
			Mrs. Dorothy Brooks 1721 Gwynns Falls Parkway
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease. (A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Metastatic Carcinoma, Primary site unknown. (C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)
			No
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)	(Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Charles S. Petty, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME OF CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Buried	12/13/65	Carver Memorial Park, Maryland	
24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 13 1965	Robert E. Fadden	Livingston Carroll	1712 W. North Ave

VS 151-REV. 1/1/65

WALTER DORRIS

PAID

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12678

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

AARON DORSEY

2. DATE AND HOUR PRONOUNCED DEAD

12-5-65

4:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1726 E. 25th STREET

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1726 E. 25 Street 21213

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

8-15-1885

9. AGE (In years
last birthday)

80 ?

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retire

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Wm Dorsey 1726 E 25th St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

CHAS. S. PETTY, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-6-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 13 1965

Robert E. Johnson

Rayner Sanders 2170 E. Preston St

WALTER H. FORGE

1000 Broadway 17th Floor
New York City

Business 12-9-68 St. Thomas, Virgin Islands
Rogers 2-10-68 2000 1st St.

1
M-640

65 12679

BALTIMORE CITY HEALTH DEPARTMENT

65 12679

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CLARENCE MURRELL

2. DATE AND HOUR PRONOUNCED DEAD

12.10.65

6.15

p.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BON SECOURS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

2544 West PRATT Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Aug. 29 - 1887

9. AGE (in years
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

FOREMAN - Empire Const

10B. KIND OF BUSINESS OR INDUSTRY

CONSTRUCTION

11. BIRTHPLACE (State or foreign country)

HOOPERSVILLE - Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

GEO. W. MURRELL

14. MOTHER'S MAIDEN NAME

HELEN RUARK

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

213-03-2167

17. INFORMANT

ADDRESS

CORA E. MURRELL 2544 W. PRATT ST.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ARTERIOSCLEROTIC CARDIOVASCULAR

(A) DUE TO

DISEASE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

PULMONARY EMPHYSEMA DUE TO BRONCHIAL ASTHMA

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12. 11. 65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

12/14/65

23C. NAME OF CEMETERY or CREMATORY

Woudon Park

23D. LOCATION

(City, town, or county)

(State)

BALTO - Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 13 1965

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

F.B. Wippert - 1300 EUTAW PLACE

ADDRESS

WHITE

FOR THE
COUNCIL OF
THE
CITY OF
NEW YORK

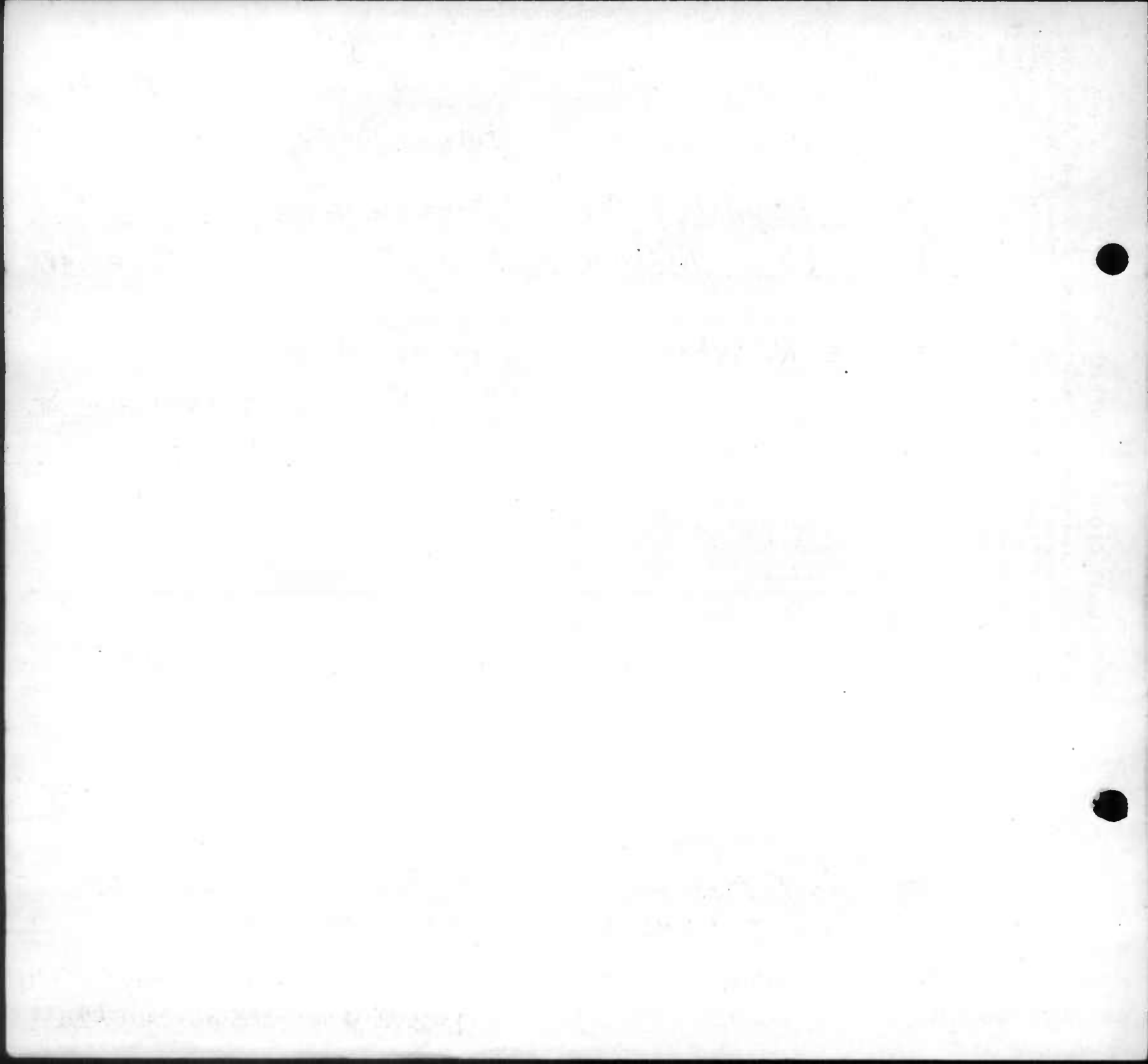
1911

1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

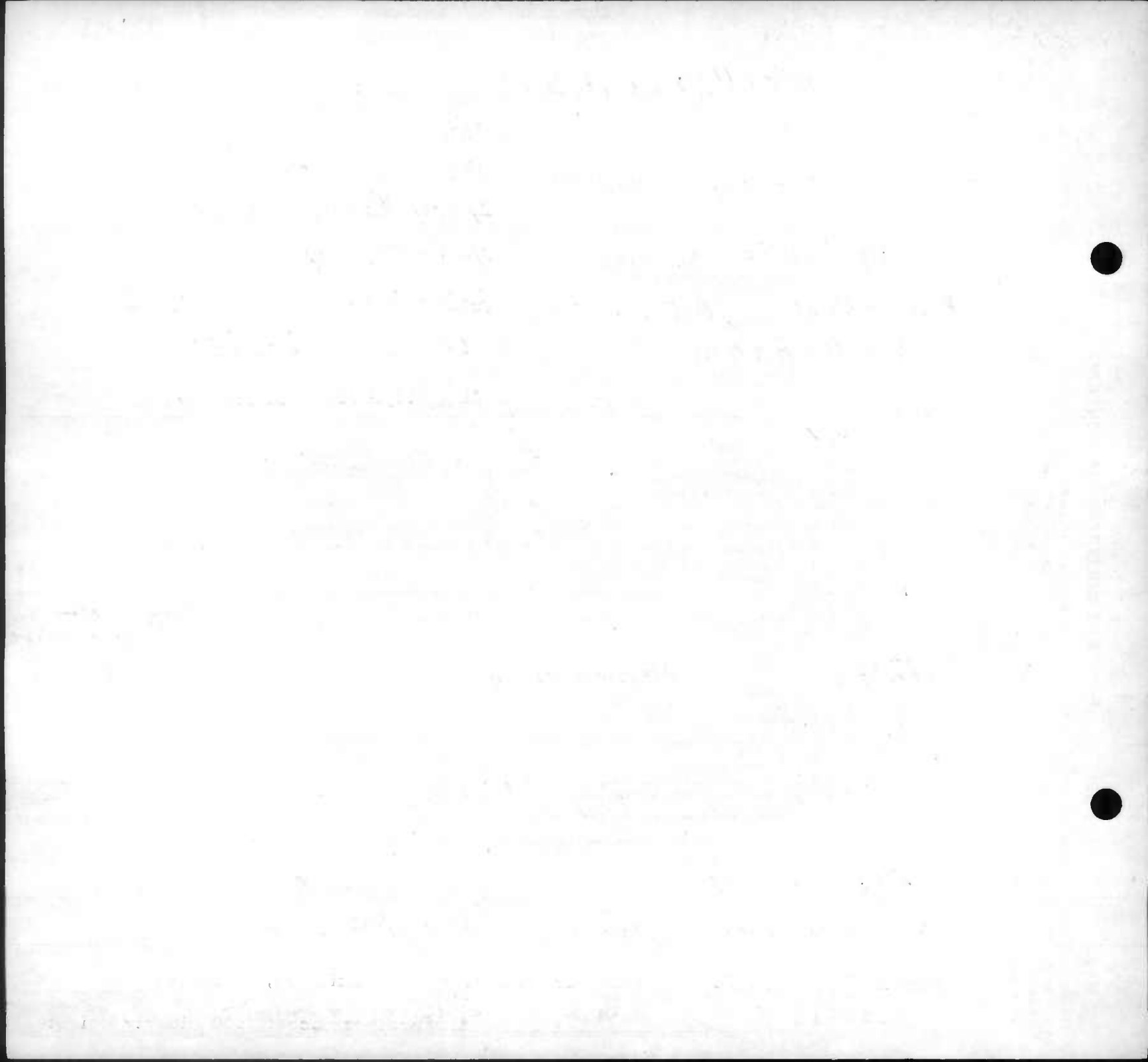
BIRTH NO. 65-30268 65 12680		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12680	
M.E. CASE NO.		CERTIFICATE OF DEATH		4	
1. NAME OF DECEASED (Type or Print) Baby Boy White		2. DATE AND HOUR OF DEATH December 11, 1965 8:00 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where decedent lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTO.			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Md.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 53-00			
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Newborn	
8. DATE OF BIRTH 12-11-65		9. AGE (In years last birthday) 2		10. CITIZEN OF WHAT COUNTRY? 48	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME BENNIE R. WHITE		14. MOTHER'S MAIDEN NAME HELEN M. WILD			
15. Was Decedent Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ELLA R. WILD-5205 BENTALOU ST.	
18. 75931		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Multiple Anomalies, Congenital			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None		(B) DUE TO			
(C) DUE TO					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-11-1965 to 12-11-1965, that (I) (we) last saw the deceased alive on 12-11-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Desideria T. Mahusay		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-11-65	
23C. PHYSICIAN'S NAME (Type) DESIDERIA T. MAHUSAY		23D. ADDRESS Lutheran Hospital of Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/13/65		24C. NAME OF CEMETERY OR CREMATORY CEDAR HILL	
24D. LOCATION 5829 Ritchie Highway A.A.C.M.		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. DEC 13 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR F. B. Wopple	
ADDRESS 1300 EUTAW PL					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

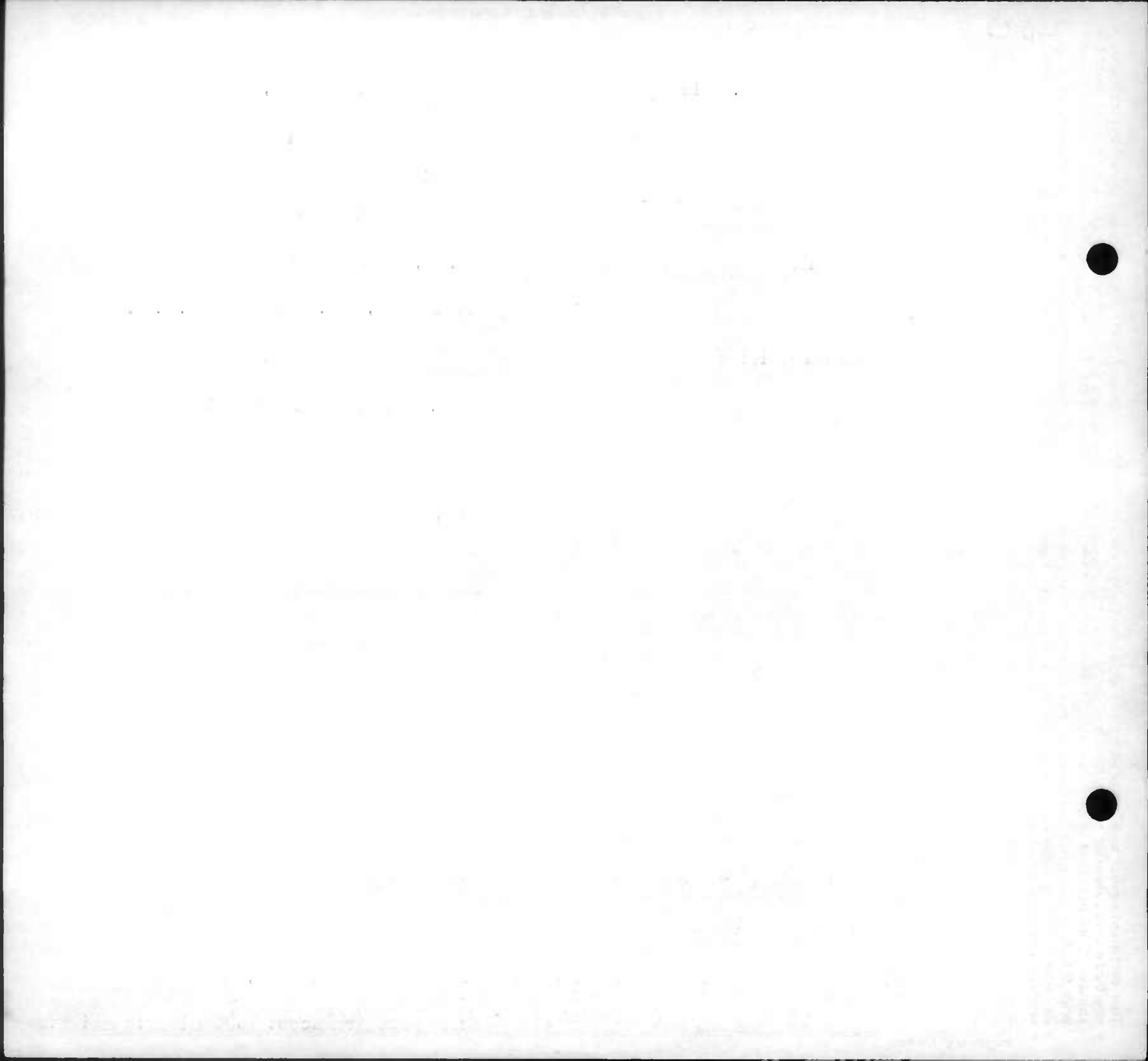
BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH								Registered No. <u>65 12681</u>			
BIRTH NO. <u>65 12681</u>		<div style="font-size: 2em; font-weight: bold;">Nicoll, Sr. Frank S.</div>						2. DATE AND HOUR OF DEATH <u>Dec. 11 1965</u> <u>830</u> P.M.			
M.E. CASE NO.								1. NAME OF DECEASED (Type or Print)			
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>		8. DATE OF BIRTH <u>4-9-1891</u>		9. AGE (In years last birthday) <u>74</u>		10. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>28-02</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>News Post</u>						10B. KIND OF BUSINESS OR INDUSTRY <u>Art Director</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nicoll, Adam</u>						14. MOTHER'S MAIDEN NAME <u>Lindsay Louise</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-09-0311</u>		17. INFORMANT <u>Louise Nicoll</u> ADDRESS <u>4504 Kathland Avenue</u>					
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Aspiration</u> INTERVAL BETWEEN ONSET AND DEATH <u>199.2</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Aspiration</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Artic. Pneumonia, Cat. Lung Rt. C. meta. t. to live</u>											
19A. DATE OF OPERATION <u>12/7/65</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Mass in abdomen</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <u>12/6/65</u> 19 <u>65</u> to <u>12/11</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12/11</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Alfred J. J. J. J.</u> M.D.						Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>12/11/65</u>		
23C. PHYSICIAN'S NAME (Type) <u>Viglundur Thor Thorsteinsson</u> M.D.						23D. ADDRESS <u>Maryl. Gen. Hosp.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/14/65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 13 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. J. J.</u>		25C. FUNERAL DIRECTOR <u>Ellsworth Armacost</u>		ADDRESS <u>4600 Liberty Heights</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12682	
BIRTH NO. 65 12682					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Maud E. Mickey		December 8, 1965			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 3801 Woodbine Avenue		A. STATE Maryland B. COUNTY Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3801 Woodbine Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min.
Female	White	Widowed	Feb. 20, 1873	92	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
At Home			Harrisburg, Pa.		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Samuel Zeigler			Ludwig		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
No		None	Sue E. Koontz 3801 Woodbine Avenue		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
334X1		(A) cerebral arteriosclerosis		Years - 4 wks.	
ANTECEDENT CAUSES		(B) generalized arteriosclerosis, CHT		Years - 6 wks.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 1 to Dec 8 19 65 , that (I) (we) last saw the deceased alive on Dec 9 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel Bakal				23B. DATE SIGNED 12.10.65	
23C. PHYSICIAN'S NAME (Type) Daniel Bakal				23D. ADDRESS 3600 Lochearn Dr. Bkto, MD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12/11/65		Druid Ridge Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 13 1965		Robert E. Talley, M.D.		Ellsworth Armacost Ellsworth Armacost 4600 Liberty Heights	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH						Registered No. 65 12683
BIRTH NO. 65 12683						
M.E. CASE NO. 65 12683						
1. NAME OF DECEASED (Type or Print) Roloff, Henry			2. DATE AND HOUR OF DEATH 12/11/65 11:30 a.m.			
3. PLACE OF DEATH IN BALTIMORE MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Balto			
FULL NAME OF HOSPITAL OR INSTITUTION 49 North Charles Gen. Hospital			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
			D. STREET ADDRESS (If rural, give location) 5510 Willys Ave. Zone 27			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) - MARRIED -	8. DATE OF BIRTH 12/20/98	9. AGE (In years last birthday) 67 yr	10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired			10B. KIND OF BUSINESS OR INDUSTRY Balto. Transit Co.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 213-05-9985		17. INFORMANT Jessie F. Roloff 5510 Willys Ave.	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarct			CAUSE OF DEATH (A) DUE TO Chronic Coronary Artery Disease		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO Myocardial Infarct			
(C) DUE TO Myocardial Infarct						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						
19A. DATE OF OPERATION 12/10/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 10. -		20A. AUTOPSY? (Yes or No) 10. -		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 12/10/65 at 3:30 p.m. to 12/11/65 19:05 , that (I) (we) last saw the deceased alive on 12/11/65 at 1:30 p.m. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE Frenkil James				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/11/65
23C. PHYSICIAN'S NAME (Type) Frenkil James				23D. ADDRESS 338 W. Pratt St. #1		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/14/65		24C. NAME OF CEMETERY OR CREMATORY Wilm Haven Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. DEC 14 1965		25B. NAME OF REGISTRAR R. A. E. F. Jones		25C. FUNERAL DIRECTOR Amber 24. 1328 Salyer St. Bal.		

1942 - 1943

1942 - 1943

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12684				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12684	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED <u>MAGDALEN</u> (Type or Print) <u>Magdalene Goeb</u>				2. DATE AND HOUR OF DEATH <u>12/12/65</u> <u>7 55</u> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland General Hospital</u> <u>827 Linden Ave 21201</u>				A. STATE <u>MD</u> B. COUNTY <u>26-36</u>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 24</u>				D. STREET ADDRESS (If rural, give location) <u>6730 Bessemer Ave</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>11-28-94</u>	9. AGE (In years last birthday) <u>71</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>PHILIP FRIESNER</u> <u>Bossy</u>				14. MOTHER'S MAIDEN NAME <u>BUSSE</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Hospital Chart</u>		
18. <u>600.0 1260X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>pyelonephritis</u>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Diabetes</u>				(A) DUE TO		(B) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>11/20</u> 19 <u>65</u> to <u>12/12</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12/12</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>John M. Steffy</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12-12-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>John M. Steffy</u>				23D. ADDRESS M.D. <u>827 Linden Ave 21201</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burnt</u>		24B. DATE <u>12-16-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 14 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Walter Dabrowski</u>		ADDRESS <u>1005 Dunbar Ave</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
BIRTH NO. 65 12685										Registered No. 65 12685	
CERTIFICATE OF DEATH											
1. NAME OF DECEASED (Type or Print) <i>Bowers, Roger</i>				2. DATE AND HOUR OF DEATH <i>12/11/65</i> <i>10:00 A.M.</i>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Washington</i>							
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Williamsport</i> REF #1 <i>71-00</i>							
				D. STREET ADDRESS (If rural, give location) <i>Falling Waters Road</i>							
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>NEVER MARRIED</i>		8. DATE OF BIRTH <i>7/1/1947</i>	9. AGE (In years last birthday) <i>18</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Student</i>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Luther Bowers</i>				14. MOTHER'S MAIDEN NAME <i>Viola Fowler</i>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>212-50-9276</i>		17. INFORMANT <i>Mr. Luther Bowers</i>		ADDRESS <i>Falling Waters Road #1 Williamsport Md REF</i>			
18. <i>92X I</i> CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)						INTERVAL BETWEEN ONSET AND DEATH <i>8 years</i>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(A) <i>Chronic glomerulonephritis</i> DUE TO					
						(B) DUE TO					
						(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <i>12/11/65</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Renal Hemodialysis</i>				20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12/11</i> 19 <i>65</i> to <i>12/11</i> 19 <i>65</i> , that (I) (we) lost saw the deceased alive on <i>12/11</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Leonard J. Hertzberg</i>								M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>12-11-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Leonard J. Hertzberg</i>								23D. ADDRESS <i>Sinai Hospital Baltimore, Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>Dec. 14 1965</i>		24C. NAME OF CEMETERY or CREMATORY <i>Greenlawn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Williamsport Md.</i>			
25A. DATE REC'D. BY HEALTH DEPT. <i>DEC 14 1965</i>						25B. NAME OF REGISTRAR <i>R. L. Leaf</i>		25C. FUNERAL DIRECTOR <i>Albert L. Leaf</i>		ADDRESS <i>Williamsport Md.</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. B-636		65 12686		CITY OF BALTIMORE		REGISTERED No. 65 12686	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Frank E. Berterman Jr.		2. DATE AND HOUR OF DEATH December 11, 1965 12:40 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		D. STREET ADDRESS (If rural, give location) 1 Willow Avenue 21206		5. SEX Male			
6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Divorced		8. DATE OF BIRTH 3-6-1885		9. AGE (In years last birthday) 80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Room		10B. KIND OF BUSINESS OR INDUSTRY Shipyard		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank E. Berterman Sr.		14. MOTHER'S MAIDEN NAME Elizabeth Johnson		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 212-09-2915		17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224					
18. 135-01		CAUSE OF DEATH Hepatoma				INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs.	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO					
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Chronic lung disease				years.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 10-26 1965 to 12-10 1965, that (1) (we) last saw the deceased alive on 12-10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Kenneth Tucker		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-11-65			
23C. PHYSICIAN'S NAME (Type) Dr. Kenneth Tucker		23D. ADDRESS M.D. 4940 Eastern Avenue Balto., Maryland 21224					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-14-65		24C. NAME OF CEMETERY or CREMATORY Mt Olivet Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 14 1965		25B. NAME OF REGISTRAR John C. Miller		25C. FUNERAL DIRECTOR ADDRESS John C. Miller Inc-6415 Belair Rd.-21206			

Indicated

W. H. H.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 12687		CERTIFICATE OF DEATH		Registered No. 65 12687		
1. NAME OF DECEASED (Type or Print) <u>George Martin</u>				2. DATE AND HOUR OF DEATH <u>12/11/65, 7:05 A.M.</u>						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>38 University Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>18-03</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>123 S. Arlington Ave</u>						
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never married</u>	8. DATE OF BIRTH <u>6/11/89</u> 83		9. AGE (In years last birthday) <u>76</u> 82	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Railroad employee</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>employee</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>George Martin</u>				14. MOTHER'S MAIDEN NAME <u>Ida Barrett</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ida Hickman</u>				ADDRESS <u>Rock Hall, Md.</u>	
18. <u>493 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u> (A) DUE TO ANTECEDENT CAUSES (B) DUE TO DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No.</u>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>12/10</u> 19 <u>65</u> to <u>12/11</u> 19 <u>65</u> , that (I) <u>we</u> last saw the deceased alive on <u>12/11</u> 19 <u>65</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> <u>did</u> (did not) view the body after death.										
23A. SIGNATURE <u>Jonathan Tuerck</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12/11/65</u>				
23C. PHYSICIAN'S NAME (Type) <u>Jonathan Tuerck</u>				23D. ADDRESS <u>University Hospital.</u>						
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/13/65</u>		24C. NAME of CEMETERY or CREMATORY <u>Wesley Chapel Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Rock Hall, Maryland</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 14 1965</u>		25B. NAME OF REGISTRAR <u>Re. J. J. J.</u>		25C. FUNERAL DIRECTOR <u>Floris Wells</u>		ADDRESS <u>Chestertown, Md.</u>				

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 12688	
BIRTH NO. 65 12688		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Miss Josephine M. Jung</i>		2. DATE AND HOUR OF DEATH <i>12-11-65 9:15 PM M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND, BALTIMORE</i> B. COUNTY <i>BALTIMORE</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> D. STREET ADDRESS (If rural, give location) <i>1748 MONTPELIER ST.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Union Memorial Hospital</i>		5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>8-6-1888</i>		9. AGE (In years last birthday) <i>77</i>	
13. FATHER'S NAME <i>JOSEPH CELKA</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-07-7498</i>		17. INFORMANT <i>HELEN JUNG; 1748 MONTPELIER ST. BALTIMORE, MD</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>arteriosclerotic cardiovascular disease</i>		18. CAUSE OF DEATH (A) <i>arteriosclerotic cardiovascular disease</i> (B) <i>coronary arteriosclerosis, stenosis</i> (C) <i>pericarditis</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MD</i>	
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>November 9</i> 19 <i>65</i> to <i>December 11</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>December 11</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>Samuel C. Gresham</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23B. DATE SIGNED <i>12-11-65</i>		23C. PHYSICIAN'S NAME (Type) <i>SAMUEL C. GRESHAM,</i>		23D. ADDRESS <i>UNION MEMORIAL HOSPITAL</i>		24. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/15/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Moreland Memorial Park</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 14 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Wm. Cook-Brooks Inc.</i>		25D. ADDRESS <i>1217 St. Paul St. 21202</i>	

Widow, Mrs. [illegible]

17-18 North [illegible] St.

8-4-1928 33

Widow, Mrs. [illegible]

17-18 North [illegible] St.

8-4-1928 33

Widow, Mrs. [illegible]

228

Widow, Mrs. [illegible]

17-18 North [illegible] St.

Widow, Mrs. [illegible]

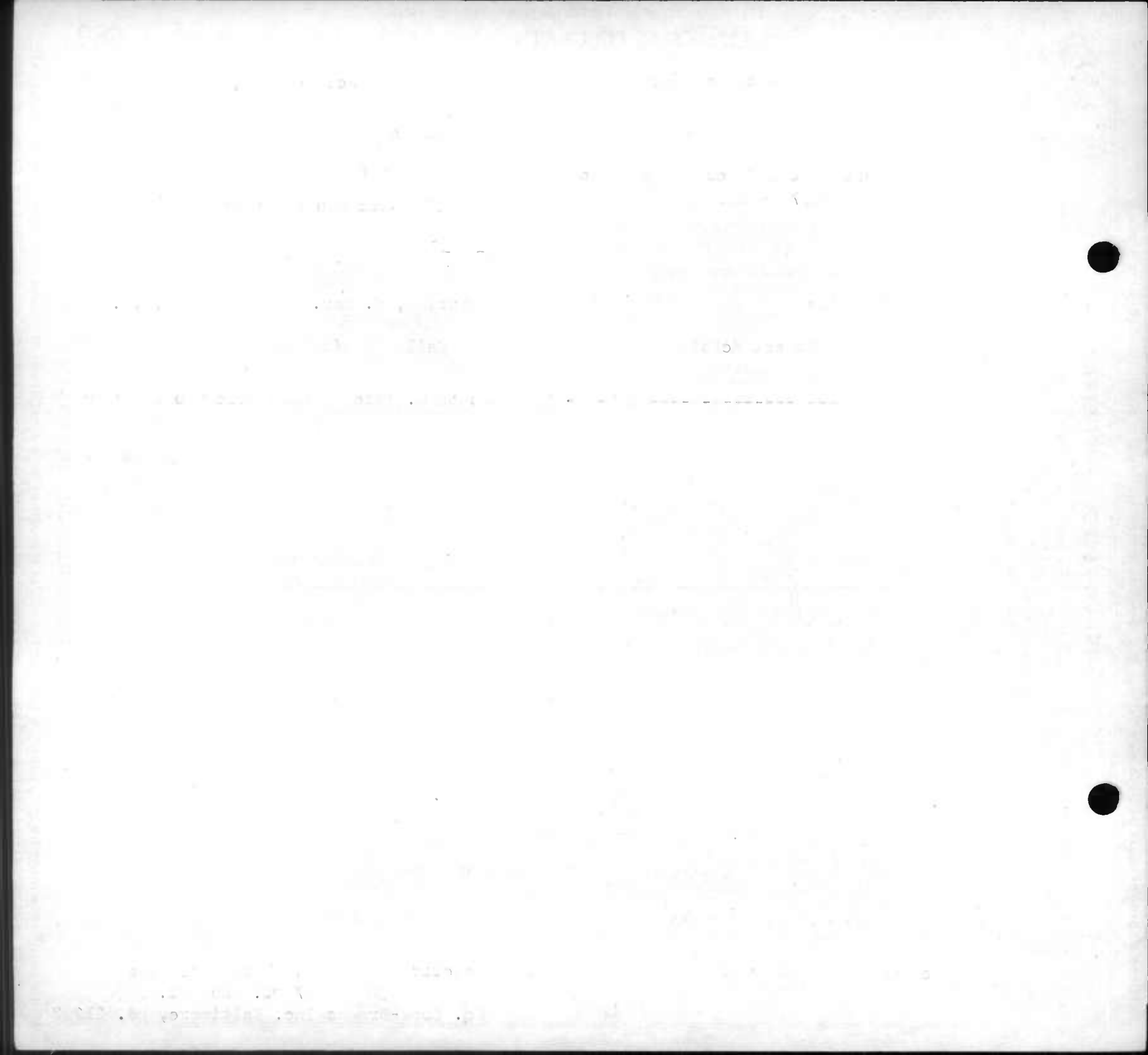
17-18 North [illegible] St.

8-4-1928 33

Widow, Mrs. [illegible]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12689	
BIRTH NO. 65 12689		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Catherine Tate		2. DATE AND HOUR OF DEATH December 10, 1965 10⁰⁰ P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION House in the Pines Bel Aire 5837 Belair Road		A. STATE Maryland B. COUNTY Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 2529 Greenmount Avenue (18)			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED Married	8. DATE OF BIRTH 8-26-88	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Marion, N. Car.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robert McCall		14. MOTHER'S MAIDEN NAME Sally (unknown)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-01-1201		17. INFORMANT ADDRESS Joseph G. Tate 2529 Greenmount Avenue (18)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA		CAUSE OF DEATH (A) DUE TO CHRONIC MYOCARDIAL DIS. (B) DUE TO GEN. ARTERIOSCLEROSIS (C) (chronic brain syndrome)		INTERVAL BETWEEN ONSET AND DEATH 12-6-65 For seven years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from August 1965 to Dec. 1965 , that (1) (we) last saw the deceased alive on Dec. 9, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alfred K. Wiedmann				23B. DATE SIGNED 12-10-65	
23C. PHYSICIAN'S NAME (Type) ALFRED K. WIEDMANN				23D. ADDRESS 715 PARK AVE - BALTIMORE 1	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 12/14/65		24C. NAME OF CEMETERY or CREMATORY Marion Cemetery	
24D. LOCATION (City, town, or county) (State) Marion, North Carolina		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR 965001		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. Baltimore, Md. 21202			



BIRTH NO.

65 12690

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 12690

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

KENNETH M. HEPLER

2. DATE AND HOUR PRONOUNCED DEAD

12-12-65

12:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

MARYLAND GENERAL HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

841 N. Eutaw Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

9-28-96

9. AGE (In years
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Ticket Taker

10B. KIND OF BUSINESS OR INDUSTRY

Movie Theater

11. BIRTHPLACE (State or foreign country)

Fairview Township, Pa.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Smiley Hepler

14. MOTHER'S MAIDEN NAME

Anne (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW1

16. SOCIAL
SECURITY NO.

214-20-9830

17. INFORMANT

ADDRESS

Clarence M. Hepler RD#1 Butler, Pa.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

12-13-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/15/65

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Catonsville, Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 14 1965

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Wm. Cook-Brooks Inc. 1217 St. Paul St.

Baltimore, Md. 21202

MAILED

1950

C-450

65 12691

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 35-56-94
65 12691

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Thomas J. Callahan

2. DATE AND HOUR OF DEATH

12/10/65

9 05 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md

Bald.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Balt. City

D. STREET ADDRESS (If rural, give location)

305 S Paca St

21201

5. SEX

m

6. RACE

w

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

sep or at

8. DATE OF BIRTH

8-2-08

9. AGE (In years
last birthday)

57

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Stock Room Clerk

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Bald, Md

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas J. Callahan

14. MOTHER'S MAIDEN NAME

Annie McDonald

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

N.

16. SOCIAL
SECURITY NO.
213-10-4787

17. INFORMANT

Patient

ADDRESS

RECORDS: BCH 4940 Eastern Avenue 21224

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Cerebral Thrombosis

(B) DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

1 day

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Tuberculosis - Alcoholism

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/17 19 65 to 12/10 19 65,
that (I) (we) last saw the deceased alive on 12/10 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

12/10/65

23C. PHYSICIAN'S
NAME (Type)

Stephen M. Nagy Jr.

M.D.

23D. ADDRESS

4940 Eastern Avenue Balto., Md. 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12/13/65

24C. NAME of CEMETERY or CREMATORY

New Cathedral Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

DEC 14 1965

25B. NAME OF REGISTRAR

Robert E. Galt

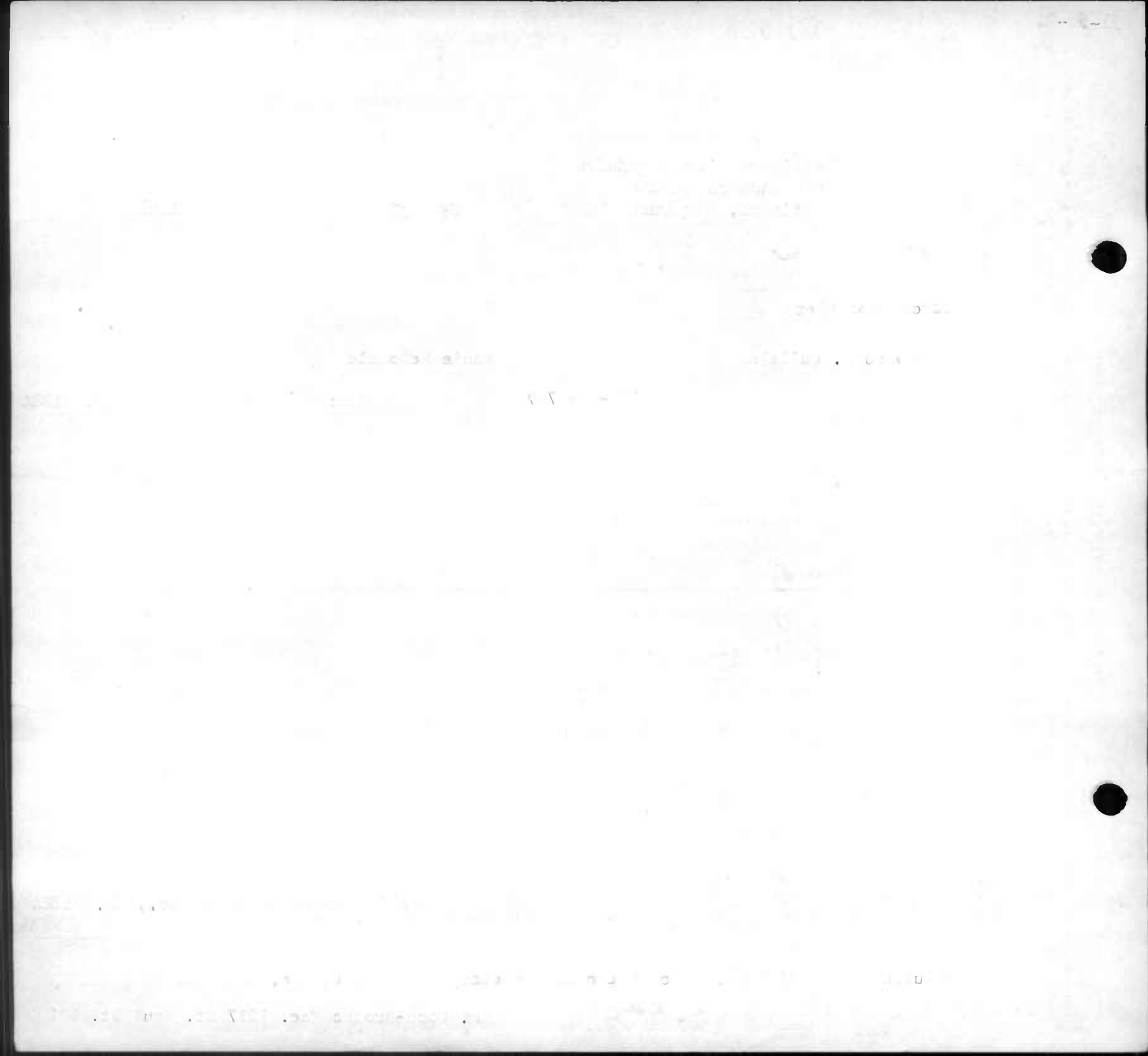
25C. FUNERAL DIRECTOR

Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

65 12692		CITY OF BALTIMORE BIRTH NO.		Registered No. 65 12692	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) PETER PHILIPPOU				12-12-65 - 6:05 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND, BALTIMORE	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
				D. STREET ADDRESS (If rural, give location) 2635 N. CALVERT ST.	
5. SEX M	6. RACE CAUC.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8-15-95	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED GROCER		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) GREECE		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME PHILLIP PHILLIPOU			14. MOTHER'S MAIDEN NAME SOPHIA TSIMON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 090-07-4939	17. INFORMANT ADDRESS GEORGE FLACKOS 2635 N. CALVERT ST		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) HEMORRAGE				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) METASTATIC TUMOR OF LIVER UNKNOWN	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 12-11-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BLEEDING TUMOR OF LIVER		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 11 19 65 to December 12 19 65 , that (I) (we) last saw the deceased alive on December 12 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Samuel C. Gresham				23B. DATE SIGNED 12-12-65	
23C. PHYSICIAN'S NAME (Type) SAMUEL C. GRESHAM		23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/15/65		24C. NAME OF CEMETERY or CREMATORY Greek Orthodox Cemetery	
		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. DEC 14 1965		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202	

WASHINGTON, D.C.

DEPARTMENT OF THE ARMY

OFFICE OF THE CHIEF OF STAFF

OFFICE OF THE CHIEF OF STAFF

10-11-41

10-11-41

SECRET

SECRET

MEMORANDUM FOR THE CHIEF OF STAFF

MEMORANDUM FOR THE CHIEF OF STAFF

10-11-41

10-11-41

MEMORANDUM

MEMORANDUM FOR THE CHIEF OF STAFF

10-11-41

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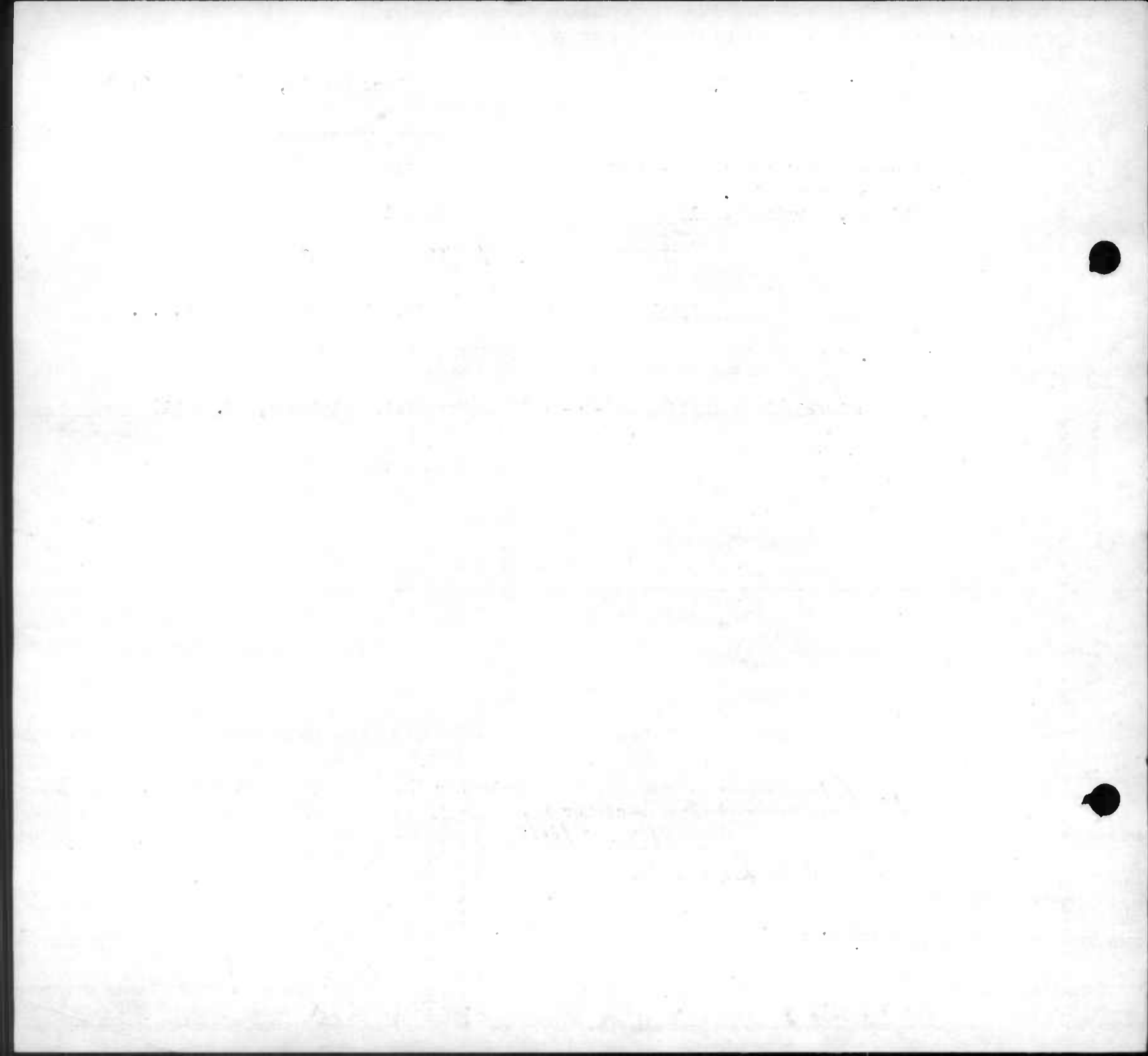
10-11-41

10-11-41

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12693		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 12693	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SMULLEN, ELMER C.		2. DATE AND HOUR OF DEATH December 10, 1965 2:20 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND, WORCESTER B. COUNTY SNOW HILL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) SNOW HILL	
FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218		D. STREET ADDRESS (If rural, give location) ROUTE # 1		23-00	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 6/22/22	9. AGE (In years, lost birthday) 43	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER		10B. KIND OF BUSINESS OR INDUSTRY PLUMBING		11. BIRTHPLACE (State or foreign country) SNOW HILL, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES C. SMULLEN		14. MOTHER'S MAIDEN NAME MARTHA JANE TRUITT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 10/23/42 To 12/1/45 216-18-8158		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS VA Hospital, Baltimore, Md. 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) RESPIRATORY INSUFFICIENCY		CAUSE OF DEATH (A) RESPIRATORY INSUFFICIENCY DUE TO (B) CARCINOMA LUNG DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 14, 1965 to December 10, 1965 , that (I) (we) last saw the deceased alive on December 14, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Paul M. Leand</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/10/65	
23C. PHYSICIAN'S NAME (Type) PAUL M. LEAND		23D. ADDRESS M.D. VA. HOSPITAL BALTIMORE, MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-13-65		24C. NAME OF CEMETERY or CREMATORY Parkley Cemetery	
24D. LOCATION (City, town, or county) (State) Parkley, Virginia		25A. DATE REC'D BY HEALTH DEPT. DEC 14 1965		25B. NAME OF REGISTRAR John A. Harris	
25C. FUNERAL DIRECTOR John A. Harris		ADDRESS Snow Hill, Md.			

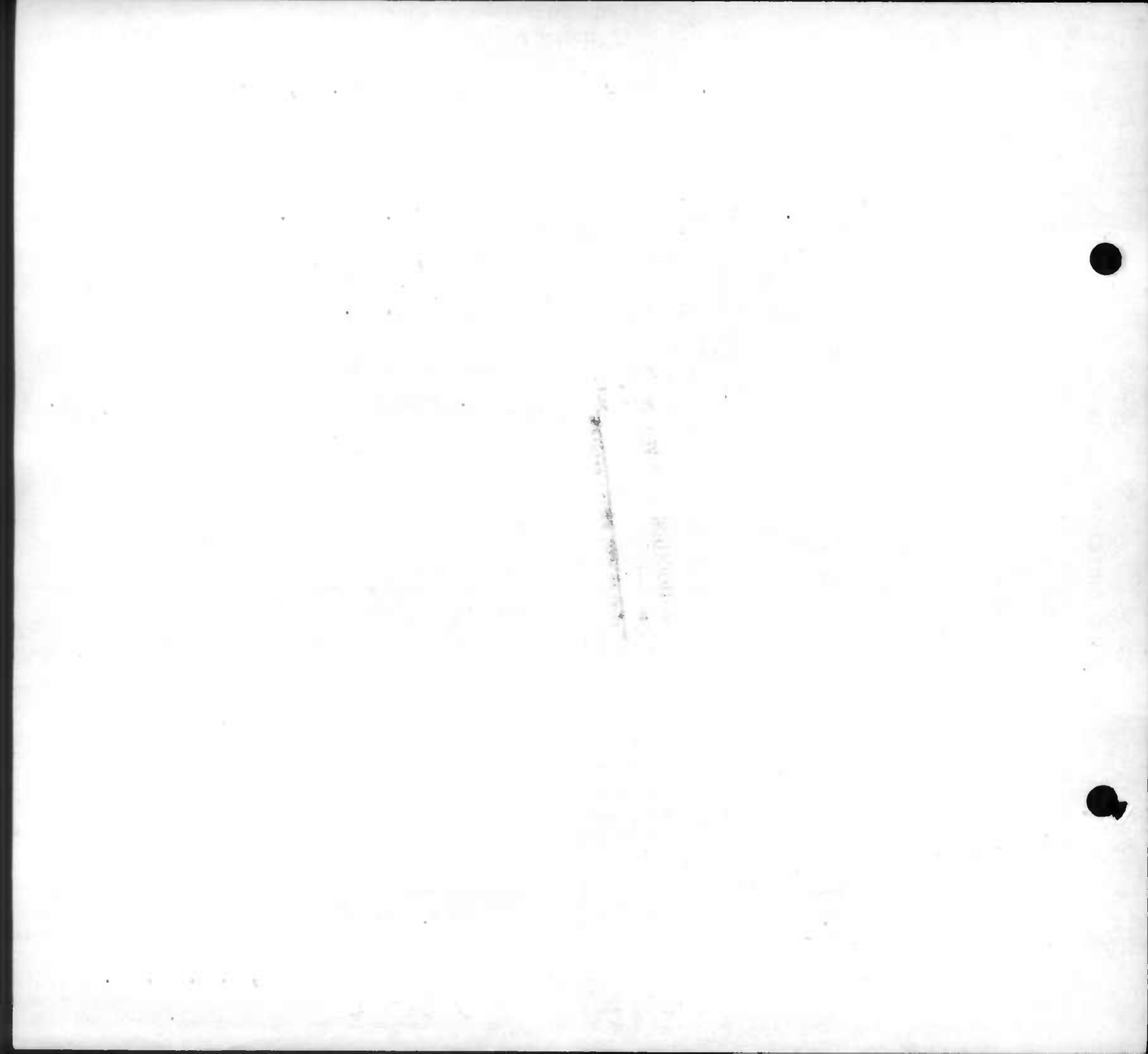


Released on approval by the Medical Examiner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

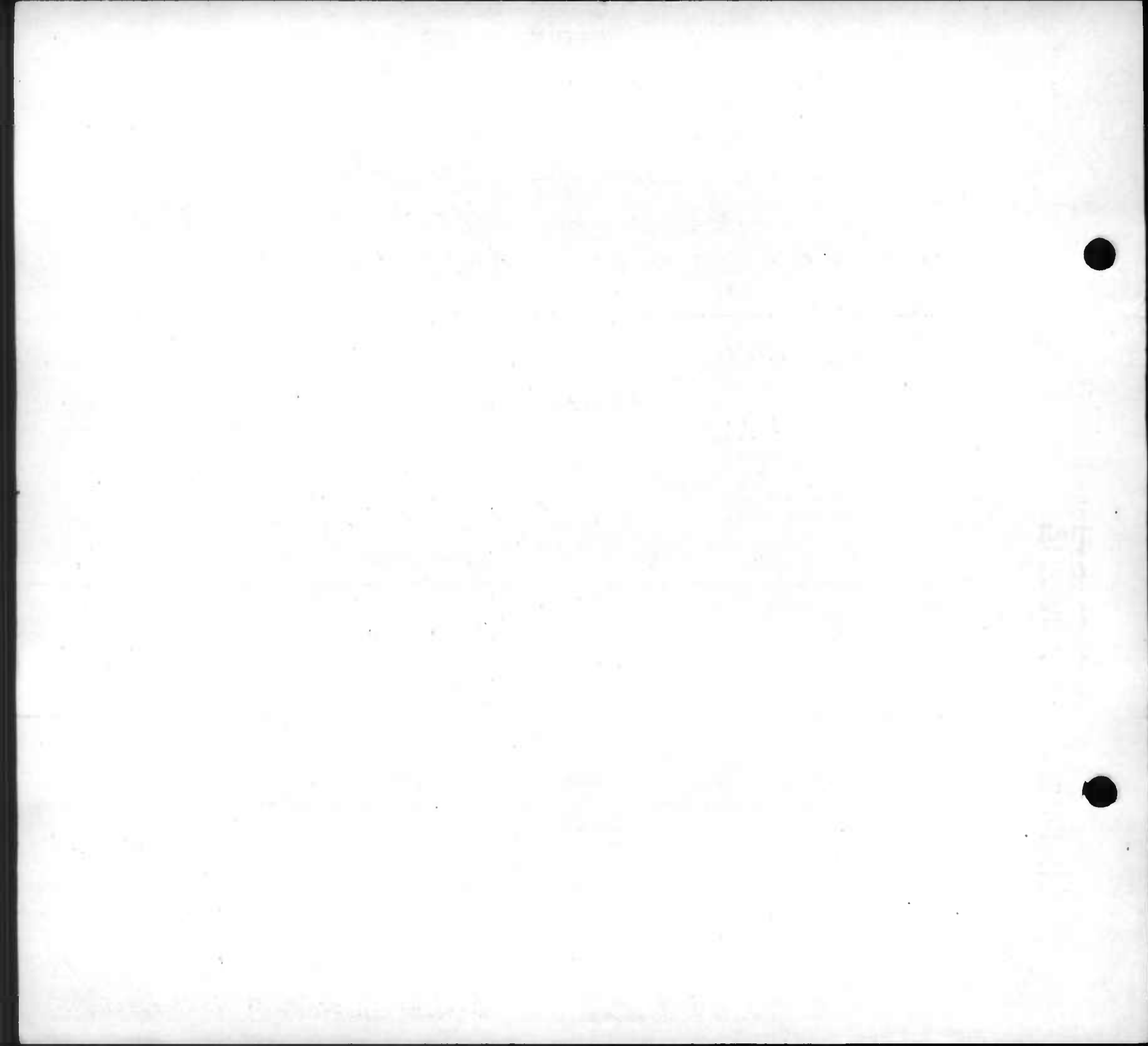
BIRTH NO. 65 12694		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 12694	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mary A. Tagmyer		2. DATE AND HOUR OF DEATH Dec. 11, 1965	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 448 E. Fort Ave		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 448 E. Fort Ave.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH April 13, 1886	9. AGE (In years last birthday) 79	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Balto. Md.	12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Ferdinand Myers			14. MOTHER'S MAIDEN NAME Julie Rossman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Frank Finley	
				ADDRESS 1202 Riverside Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease or injury or complication which caused death.) 420.1 I CORONARY OCCLUSION		CAUSE OF DEATH (A) DUE TO Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 1 day	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last. II ARTERIOSCLEROSIS		(B) DUE TO Arteriosclerosis		1 yr. +	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec. 11, 1965 to death on arrival that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Sollod		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-11-65	
23C. PHYSICIAN'S NAME (Type) A. Sollod		23D. ADDRESS M.D. 707 E. Fort Ave			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12 14 1965		24C. NAME OF CEMETERY or CREMATORY Glen Haven	
24D. LOCATION Glen Burnie, A. A. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 14 1965			
25B. NAME OF REGISTRAR J. C. Galt		25C. FUNERAL DIRECTOR ADDRESS 130 E. Fort Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12695				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12695	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CATHERINE PADUSKY				2. DATE AND HOUR OF DEATH DECEMBER 8, 1965 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 103			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital) or institution, give street address or location 604 S. LUZERNE AVE				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
D. STREET ADDRESS (If rural, give location) 604 S. LUZERNE AVENUE							
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH AUGUST 18, 1909	9. AGE (In years last birthday) 56 YRS.	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES BELL				14. MOTHER'S MAIDEN NAME SARA FEBIS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-24-9075		17. INFORMANT MRS. LOUISE VINTON 8004 BANK ST.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 443X14260X Congestive Heart Failure Hypertensive C. V.D. Analyzed Autopsy INTERVAL BETWEEN ONSET AND DEATH				CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? Yes or No No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from Jan 1955 to Dec 8 1965, that (I) (we) last saw the deceased alive on 12/6 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Melvin J. Jaworski M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/10/65	
23C. PHYSICIAN'S NAME (Type) MELVIN J. JAWORSKI M.D.				23D. ADDRESS 2711 EASTERN AVE BALTO MD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE DEC. 11, 1965		24C. NAME OF CEMETERY or CREMATORY SCHWARTZ'S CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE MD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 14 1965		25B. NAME OF REGISTRAR R. J. F. F.		25C. FUNERAL DIRECTOR RAYMOND L. SACZOROWSKI 2525 FLEET ST.			



BIRTH NO.

65 12696

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12696

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT

WILSON

2. DATE AND HOUR PRONOUNCED DEAD

December 10, 1965

3:20 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Maryland General Hospital ✓

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1776 N. Gay Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

12-13-42

9. AGE (In years
last birthday)

22

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Porter

10B. KIND OF BUSINESS OR INDUSTRY

RESTAURANT

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

7

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple Traumatic Injuries.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Jones Falls Expressway, Baltimore

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12 10 '65 A

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Passenger in auto into fixed object.

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/10/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

12/14/65

23C. NAME OF CEMETERY or CREMATORY

MT. CARMEL

23D. LOCATION

(City, town, or county)

(State)

A.A. County, Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 14 1965

24B. NAME OF REGISTRAR

Robert E. Fink, M.D.

24C. FUNERAL DIRECTOR

Joseph G. Lockhart

ADDRESS

1304 N. Central Ave

Between

1 Cabaret 7 St. Paul Stc.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. #-130		65 12697		Baltimore City Health Department		CERTIFICATE OF DEATH		Registered No. 65 12697	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HAUPT, Jacob				2. DATE AND HOUR OF DEATH 12/10/65 2:50 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 53-00 D. STREET ADDRESS (If rural, give location) 309 N. Marlyn Avenue 21221				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED Married		8. DATE OF BIRTH 12/10/65 93	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baltimore City Police Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Joseph Haupt				14. MOTHER'S MAIDEN NAME Anna Barbara ?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: BCH, 4940 Eastern Ave., Balto. Md.			
18. E954IX DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest Myocardial Infarction hypertension Spinal anaesthesia INTERVAL BETWEEN ONSET AND DEATH 15 min					CAUSE OF DEATH Cardiac arrest Myocardial Infarction hypertension Spinal anaesthesia				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) state the UNDERLYING CONDITION last. II Myocardial Infarction					OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION 12/10		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BPH		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12/10 19 65 to 12/10 19 65 , that (I) (we) last saw the deceased alive on 12/10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE R. W. Bridge						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/10/65	
23C. PHYSICIAN'S NAME (Type) R. W. Bridge						23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/14/65		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) (State) Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 14 1965		25B. NAME OF REGISTRAR R. W. Bridge		25C. FUNERAL DIRECTOR Crumley Sons		ADDRESS 300 Mac Ave. Balto. 21			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 12698					CERTIFICATE OF DEATH					Registered No. 65 12698				
1. NAME OF DECEASED (Type or Print) Mrs. Jessie M. Ballentine					2. DATE AND HOUR OF DEATH December 11, 1965 7:35 A.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5 Church Home and Hospital					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 526 Riverside Drive									
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 5/15/1907		9. AGE (In years last birthday) 58		10. If Under 1 Yr. Months: Days		10. If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Maryland				
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME William Burke					14. MOTHER'S MAIDEN NAME Phyrn Fetter				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 217-18-6908					17. INFORMANT Husband (Same as above)				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 121X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) ANEMIA SECONDARY TO HYDRO NEPHROSIS DUE TO (B) URETERAL STRICTURE DUE TO (C) CANCER OF CERVIX treated BY RADIATION + HYSTERECTOMY 1964					INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) Yes				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 12/14 1965 to 12/11 1965, that (I) (we) lost saw the deceased alive on 12/11 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE Mario A. Tolentin					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED 12/11/65				
23C. PHYSICIAN'S NAME (Type) MARIO A. TOLENTINO					M.D. 23D. ADDRESS CHURCH HOME + HOSPITAL									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 12/13/65					24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith				
24D. LOCATION (City, town, or county) (State) Balto. Co. Md.					25A. DATE REC'D BY HEALTH DEPT. DEC 14 1965					25B. NAME OF REGISTRAR R. E. F. J. J.				
25C. FUNERAL DIRECTOR Carmello J. J. J.					ADDRESS 300 Mace Ave. Balto. Md.									

Mr. James M. Baltimore, Md. 21224

Maryland

Baltimore

256 Riverside Drive

8/12/1903 28

Maryland

Physician

Church Home and Hospital

Female White Married

Housewife

William Burke

Yes

1

65 12699

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12699

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

CHARLES BLOSS

2. DATE AND HOUR PRONOUNCED DEAD

Dec. 11, 1965 2:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
MarylandB. COUNTY
Essex

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore Co. - Essex

D. STREET ADDRESS (If rural, give location)

706 Mace Ave.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

6/8/83

9. AGE (In years
last birthday)

82

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Builder

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Bloss

14. MOTHER'S MAIDEN NAME

Maria Liem

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

M. A. Bloss 706 Mace Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Hemoperitoneum due to rupture of
spleen.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

Mace Ave., Essex - Baltimore Co., Md.

21D TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
Dec. 4, 65 3:15 A.M.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Struck by car while crossing the street

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREWerner U. Spitz, M.D.
EXAMINER'S NAME (Type)CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Dec. 11, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/15/65

23C. NAME of CEMETERY or CREMATORY

Oak Lawn

23D. LOCATION

(City, town, or county)

Balto. Co.

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 14 1965

24B. NAME OF REGISTRAR

Robert E. Spitz

24C. FUNERAL DIRECTOR

Connelly Sons 300 Mace Ave. Balto.

ADDRESS

VALLEY FORGE

NO. 1000

1000

1000

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12700		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 12700	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MR. ANDREW FLECKENSTEIN			
2. DATE AND HOUR OF DEATH 12-10-65 11:35 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTO.			
FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSP. INC		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.			
		D. STREET ADDRESS (If rural, give location) 518 Dorsey Ave.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2/23/98	9. AGE (In years last birthday) 67	10. Under 1 Yr. Months Days Hours Min. 11:35 P.M.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fire Dept. (Retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTO.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jacob Fleckenstein		14. MOTHER'S MAIDEN NAME Mary Kriller	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 820-44-5923		17. INFORMANT Wife (Same as above)	
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cerebral Vascular Accident (B) Arteriosclerotic Vascular Disease (C) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 5 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Anterior Myocardial Infarction		10 days	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-1-65 to 12-10-65 , that (I) (we) last saw the deceased alive on 12-10-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ruperto Manankil		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-10-65	
23C. PHYSICIAN'S NAME (Type) RUPERTO MANANKIL		23D. ADDRESS Mercy Hospital Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/15/65		24C. NAME of CEMETERY or CREMATORY Oak Lawn	
24D. LOCATION (City, town, or county) BALTO. CO.		24E. STATE MD.			
25A. DATE REC'D BY HEALTH/DEPT. DEC 14 1965		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR John J. Connelly	
				ADDRESS 300 Maudslayi	

Rupert Mawson
Rupert Mawson

12-10-10 12-10-10

MERCY HOSP. INC.

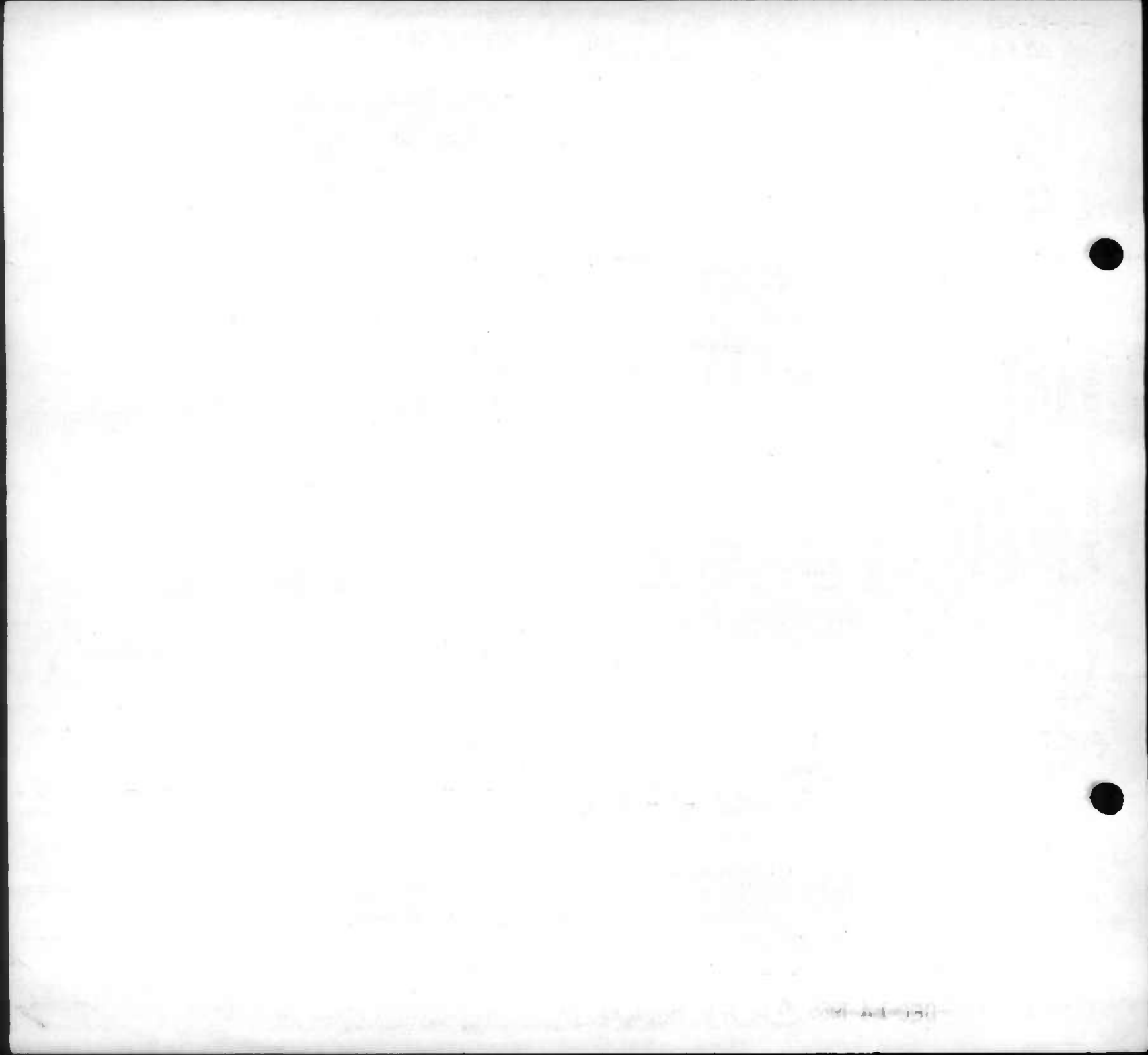
M W

MR. ANDREW W. FLETCHER JR. 12-10-10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased deceased prior to death; and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65-29886 65 12701		REGISTERED NO. 65 12701	
M.E. CASE NO. 1		2	
1. NAME OF DECEASED (Type or Print) MERCER, Deborah half girl		2. DATE AND HOUR OF DEATH 11-28-65 9:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital		A. STATE Maryland B. COUNTY Baltimore	
5. SEX F		6. RACE N	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED		8. DATE OF BIRTH 11-28-65	
9. AGE (In years lost birthday) 0		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Roland Mercer		14. MOTHER'S MAIDEN NAME Deborah Bjrd	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	
Records: BCH-4940 Eastern Avenue		21224	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		5 min	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work Not While At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-28-1965 to 11-28-1965 that (I) (we) last saw the deceased alive on 11-28-65 11:15 P.M. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE M. Haduegh		23B. DATE SIGNED 11-28-65	
23C. PHYSICIAN'S NAME (Type) M. Haduegh		23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremated		24B. DATE 12-1-1965	
24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals		24D. LOCATION Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 14 1965		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR		25D. ADDRESS	
HOSPITAL DISPOSAL			



CERTIFICATE OF DEATH

Registered No. 65 12702

BIRTH NO. 45-29740-65 12702

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Baby Boy Rudd, Irene

2. DATE AND HOUR OF DEATH

12/5/65

5:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Baltimore City Hospitals.

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Maryland new born

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

122 South Eden Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

12/2/65

9. AGE (In years
last birthday)

0

If Under 1 Yr.
Months: Days: Hours: Min.

0

3

0

3

0

3

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

USA.

13. FATHER'S NAME

Charles Rudd.

14. MOTHER'S MAIDEN NAME

Irene

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

—

17. INFORMANT BCH 4940 Eastern Avenue

Records Chart

18. 773.5 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) Resp. Distress Syndrome
DUE TO Pre. Hyaline Membrane D.s.(B) Prematurity
DUE TO

(C)

3

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Icterus Neonatorum

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

NO

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
WorkNot While
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec 2/ 1965 to Dec 5 1965.
that (I) (we) last saw the deceased alive on Dec 5 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Edward A. Jacobs

Attending
Phys.Med.
DirectorStill
Phys.

23B. DATE SIGNED

12/5/65

23C. PHYSICIAN'S
NAME (Type)

Edward A. Jacobs

23D. ADDRESS

M.D.

4940 Eastern Avenue, Maryland, Baltimore,

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

Cremated

12-7-1965

Baltimore City Hospitals Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

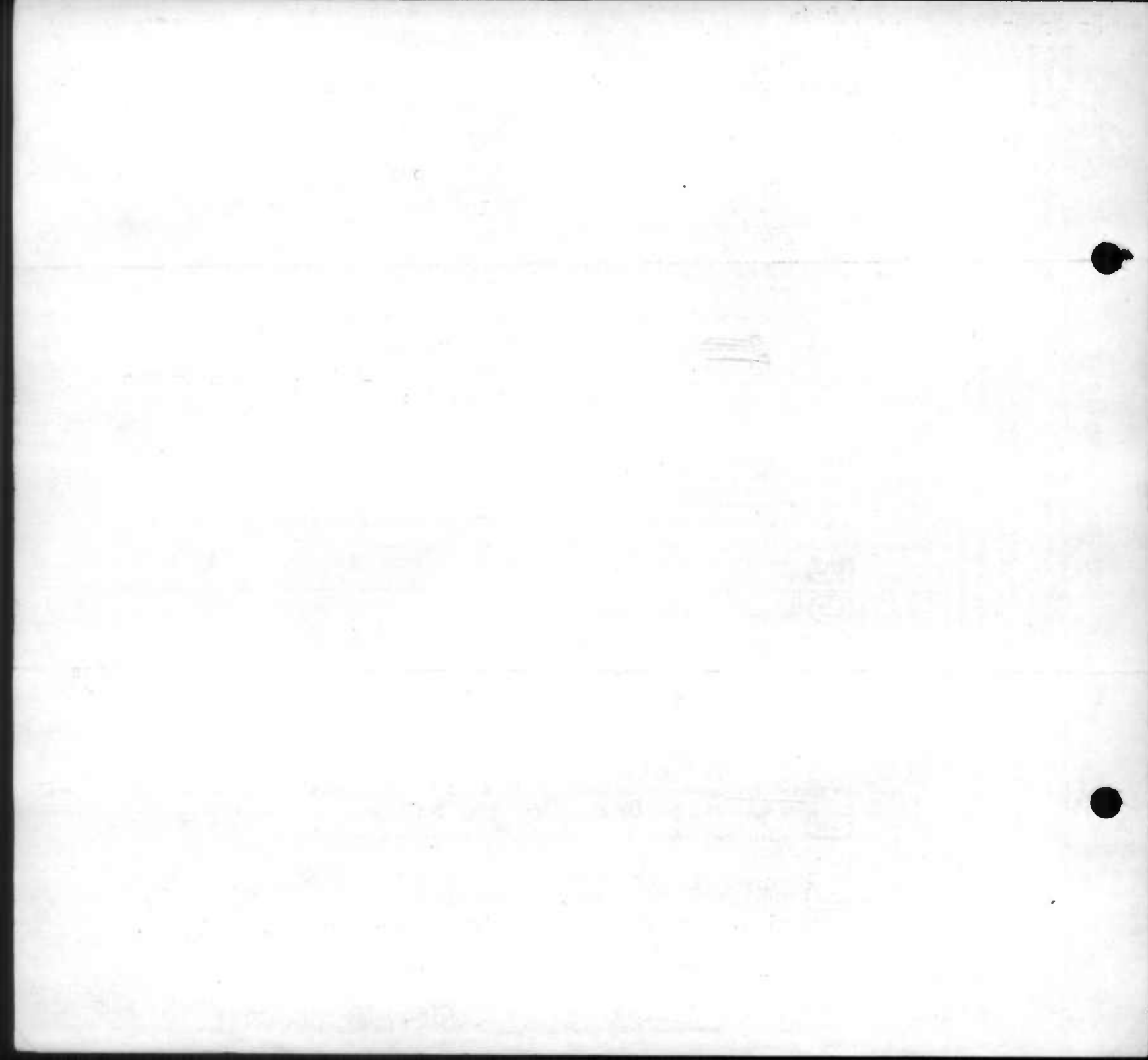
ADDRESS

DEC 14 1965

HOSPITAL DISPOSAL

FUNERAL DIRECTOR: IMPORTANT

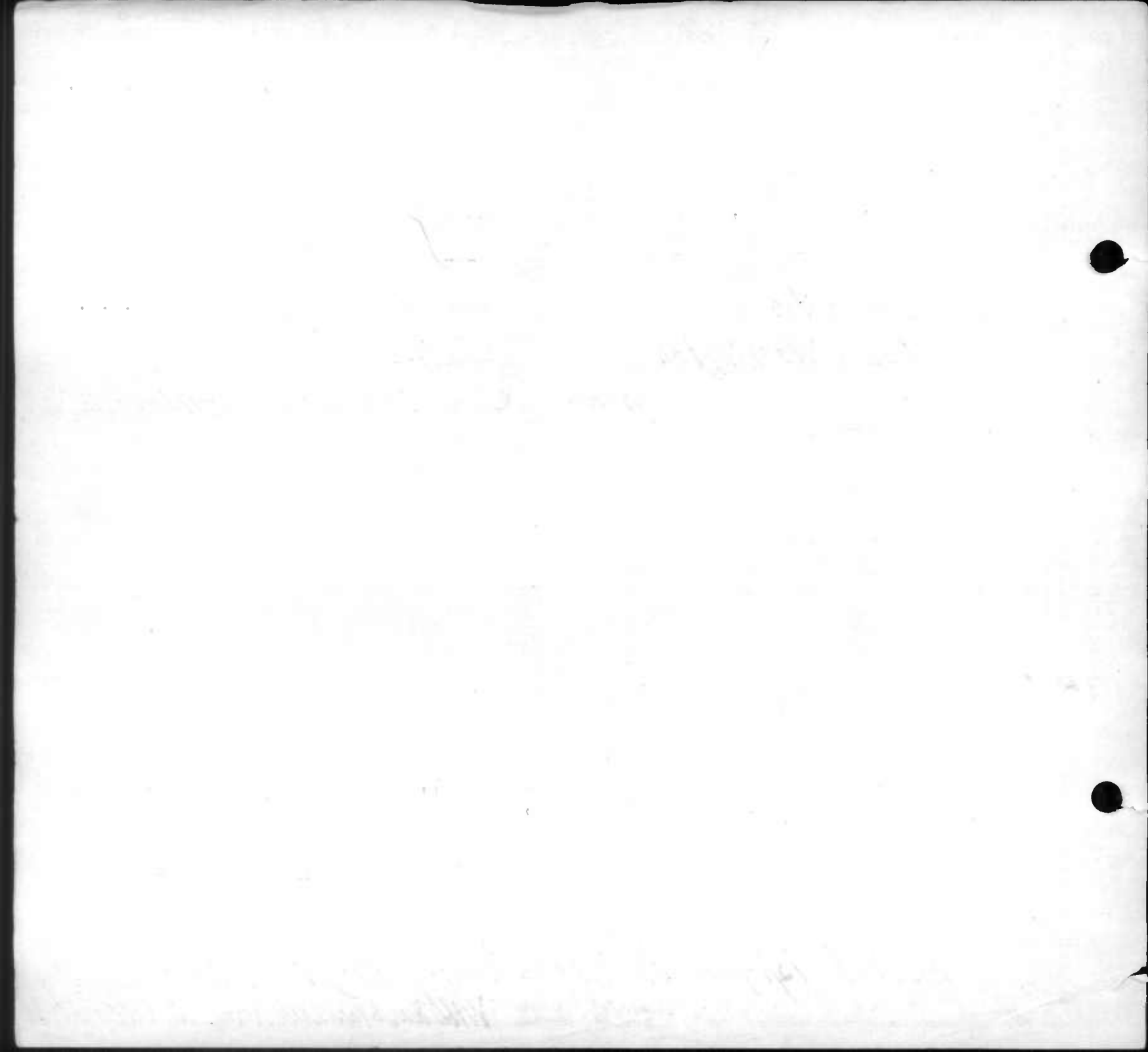
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		65 12703	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Ethel Arthur			December 9, 1965 12:15 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
Provident Hospital 1514 Division Street Baltimore, Maryland			Maryland 14-02		
5. SEX Female			6. RACE Negro		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed			8. DATE OF BIRTH 5-5-1896		
9. AGE (In years last birthday) 69			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		
11. BIRTHPLACE (State or foreign country) Pittsburg Pa.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Louis Washington			14. MOTHER'S MAIDEN NAME Julia		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		
17. INFORMANT Jean Deskins Lee			ADDRESS 1411 Division St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 2.60X I			CAUSE OF DEATH (A) Gangrene of both feet (B) Diabetes mellitus (C) Marked peripheral arteriosclerosis		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 7, 1965 to December 9, 1965, that (I) (we) last saw the deceased alive on December 9, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 12-9-65	
23C. PHYSICIAN'S NAME (Type) A. RIGAUD				23D. ADDRESS 1514 Division Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/14/65		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
24D. LOCATION Baltimore		24E. NAME OF REGISTRAR R. E. [Signature]		24F. FUNERAL DIRECTOR Williams Funeral Home	
24G. DATE REC'D BY HEALTH DEPT. DEC 14 1965		24H. NAME OF REGISTRAR R. E. [Signature]		24I. FUNERAL DIRECTOR Williams Funeral Home	
24J. ADDRESS 314		24K. ADDRESS H. Schroeder St.			



65 12701

BALTIMORE CITY HEALTH DEPARTMENT

65 12704

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LINWOOD MORGAN

2. DATE AND HOUR PRONOUNCED DEAD

Dec. 11, 1965, 1:55 A.M.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street
address or location)

University Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

942 Mulberry Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Sep.

8. DATE OF BIRTH

April 11, 1932

9. AGE (In years
last birthday)

33

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Lorionburg Co. Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Harry Morgan

14. MOTHER'S MAIDEN NAME

Annie Lhee

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

327-40-4120

17. INFORMANT

ADDRESS

Annie Morgan 942 N. Mulberry St.

18.

E981X

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Gunshot wounds of chest and abdomen
involving heart, lung, liver and sto-
mach.(A) ~~XXXX~~

(B) DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

ii

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

315 N. Pine St., Baltimore

21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

Dec. 11 65 1:25 AM

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

allegedly shot by wife

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12.11., 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/15/1965

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem. Balto. Md.

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 14 1965

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

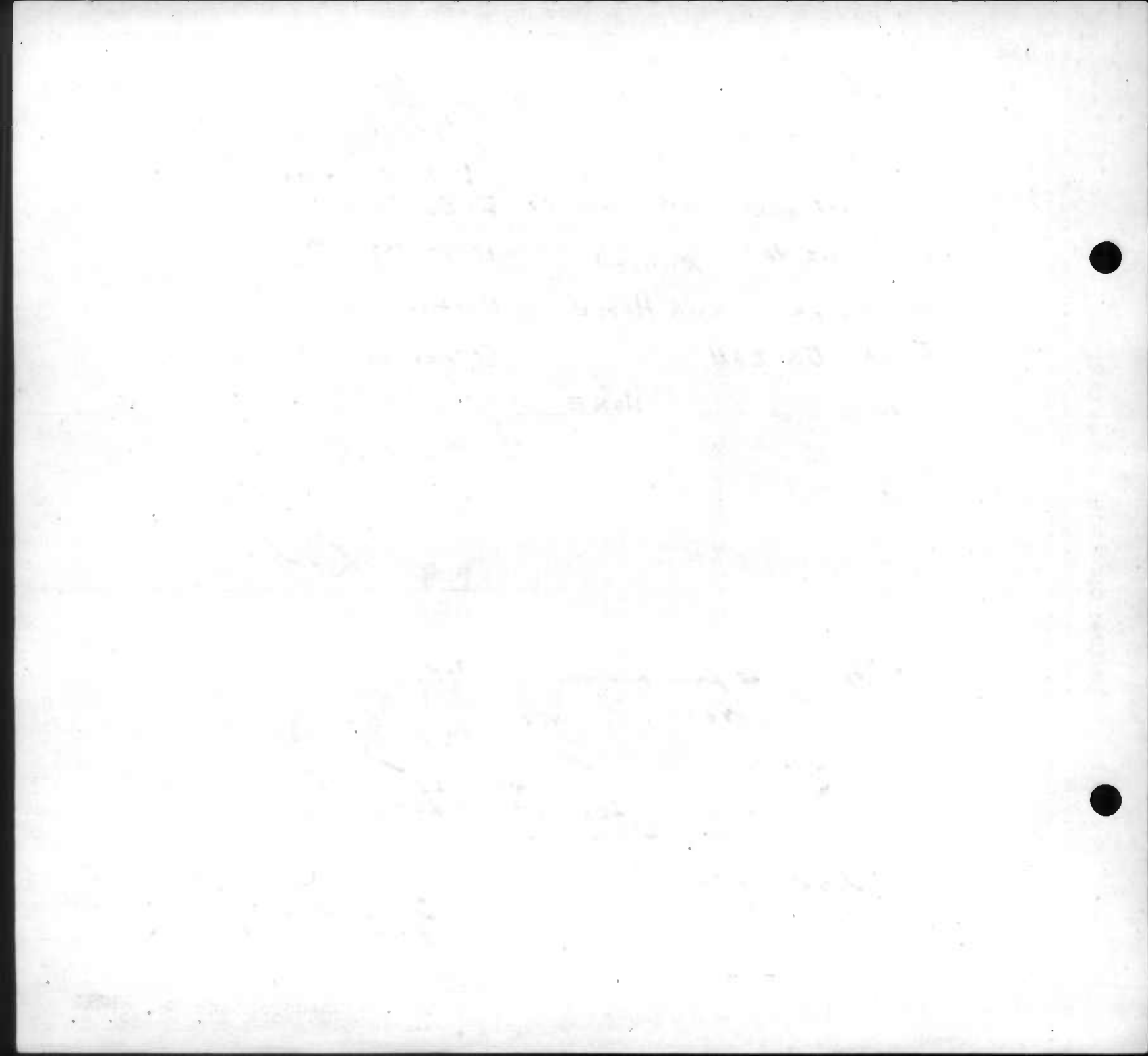
319 N. Schroeder St.

WALTER P. BROWN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12705		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 12705	
1. NAME OF DECEASED (Type or Print) Ritter, Alice Cecelia			2. DATE AND HOUR OF DEATH Dec. 13, 1965 3.30 p. m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Florida B. COUNTY V-08		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital Baltimore, Maryland 18			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Venice, Florida		
D. STREET ADDRESS (If rural, give location) W. Bay Drive, Box 882, Venice, Florida					
5. SEX Female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 11/23/93	9. AGE (In years lost birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) Buffalo N. Y.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Frank Bartoll			14. MOTHER'S MAIDEN NAME Catherine Mc Dermont		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS Mr. Frederick D. Ritter Same
18. 5-87.01			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Peritonitis			(A) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO Acute pancreatitis		
			(C) ful.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2 No major operation at present admission		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Nil		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) No	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) Nil		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input checked="" type="checkbox"/>	
22. I certify that he (this hospital) attended the deceased from Nov. 28 19 65 to Dec. 13 19 65 , that he (we) last saw the deceased alive on Dec. 13 19 65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. He (We) did (did not) view the body after death.					
23A. SIGNATURE Wang Fan				23B. DATE SIGNED Dec. 13-65	
23C. PHYSICIAN'S NAME (Type) K. Fan		23D. ADDRESS Union Memorial Hospital Baltimore, Maryland 18			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-16-1965		24C. NAME OF CEMETERY or CREMATORY St. Paul's Cemetery Owosso, Mich.	
25A. DATE REC'D BY HEALTH DEPT. DEC 14 1965		25B. NAME OF REGISTRAR Henry W. Jenkins & Sons Co.		25C. FUNERAL DIRECTOR ADDRESS 21212 4905 York Rd. Balt. Md.	



BIRTH NO.

65 12706

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HENRY

GENIUS

2. DATE AND HOUR PRONOUNCED DEAD

December 5, 1965

6:40 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

626 Pitcher Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

DIVORCED

8. DATE OF BIRTH

?

9. AGE (In years
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Laborer

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs SHIRLEY TYLER 527 Argyle Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Stab Wound of Abdomen.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.) House21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
606 Pitcher Street21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12 5 '65 A

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Stabbed during altercation.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/5/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/13/65

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

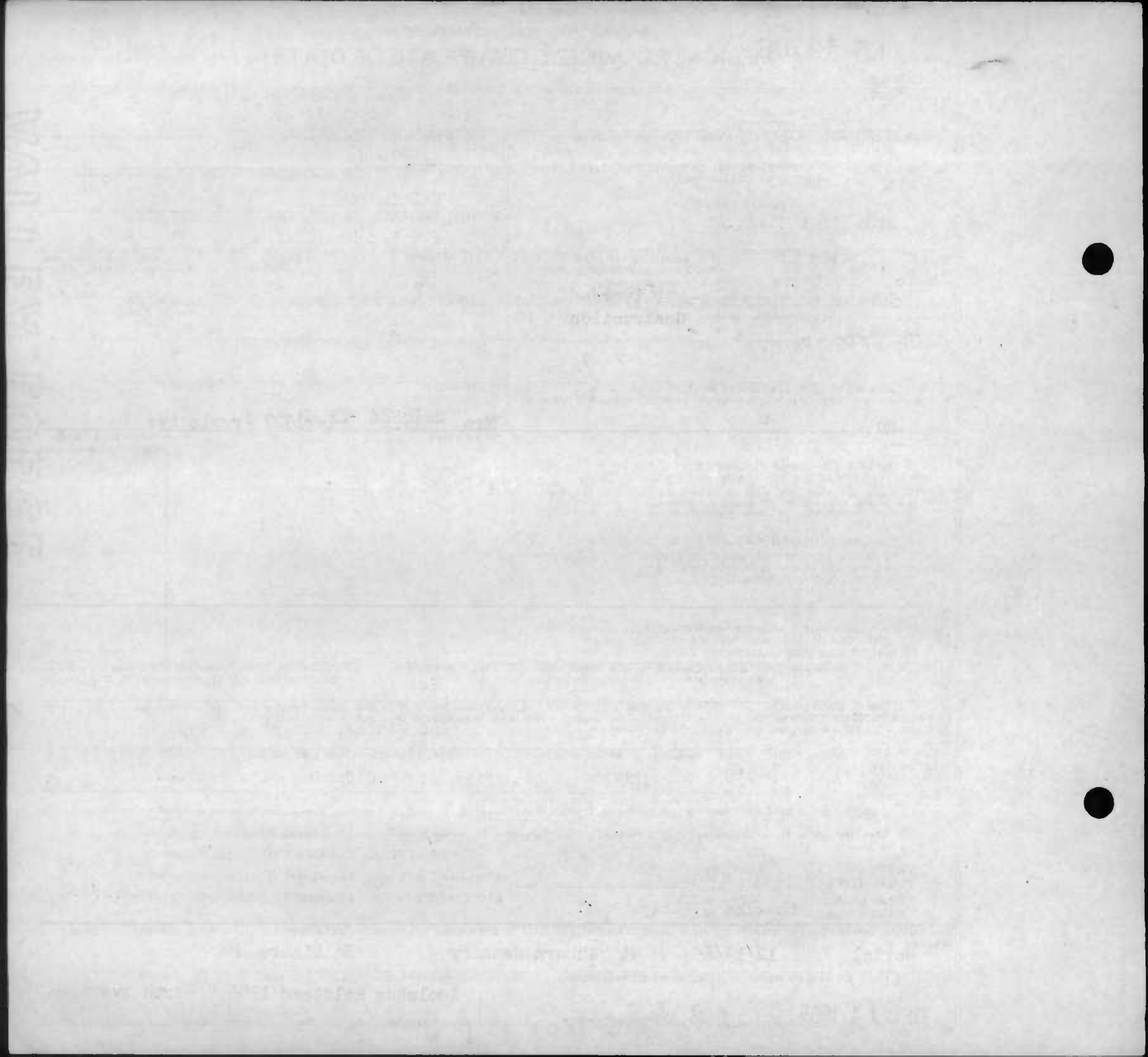
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Adolphus Halstead 1206 W North Ave

DEC 14 1965



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FANNIE

S.

MARTIN

2. DATE AND HOUR PRONOUNCED DEAD

December 8, 1965

11:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1202 Eutaw Place

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1202 Eutaw Place

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

?

9. AGE (In years
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Sanford N Carolina

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William D McIver

14. MOTHER'S MAIDEN NAME

Mary Agnes

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

M. McIver 1509 Rutland Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/9/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/13/65

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cemetery

23D. LOCATION

(City, town, or county)

(State)

A A County Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 14 1965

Robert E. Johnson

Adolphus Halstead

1206 North Ave

VALLEY BOULEVARD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

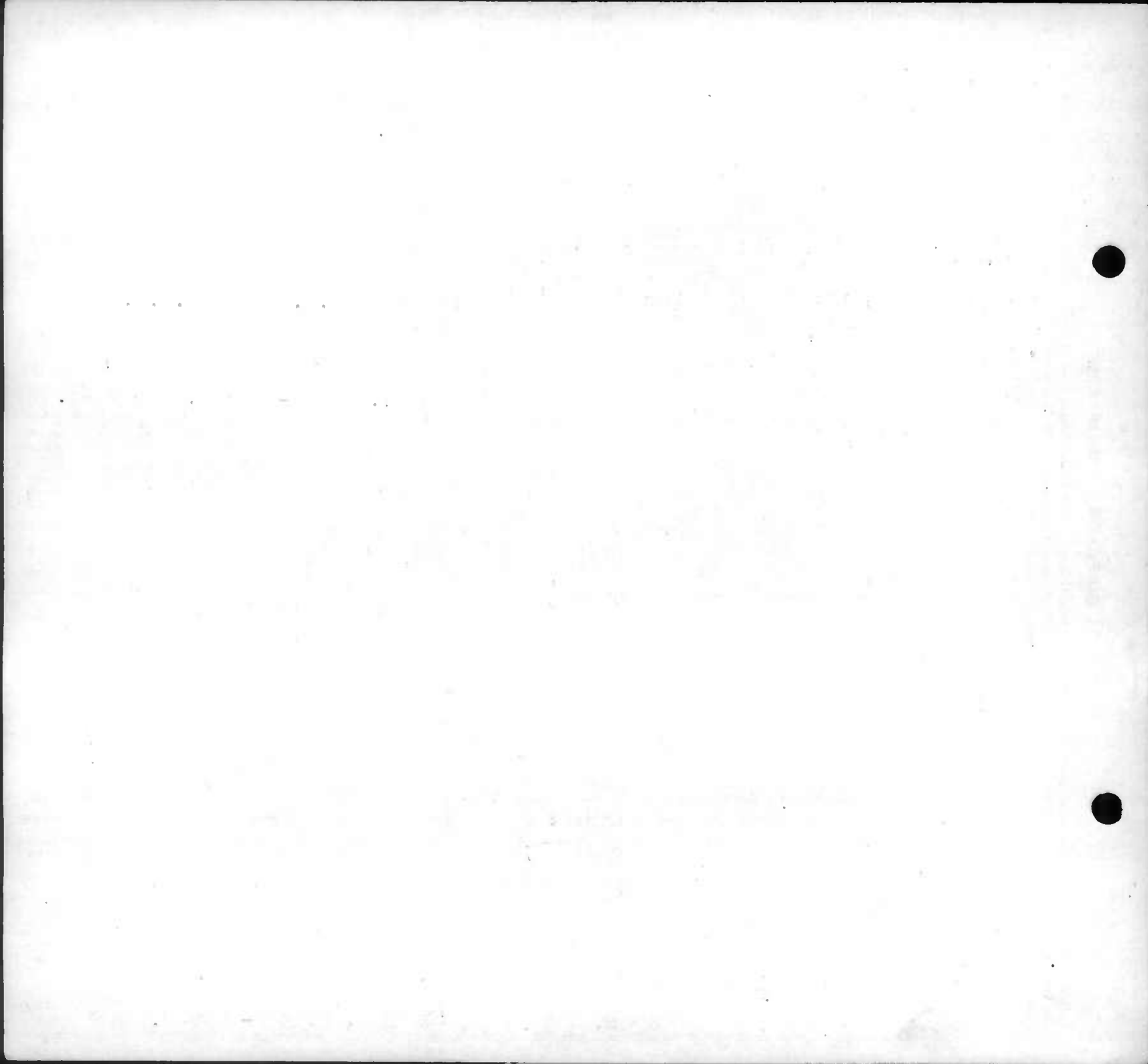
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 12708	
BIRTH NO. 65 12708		M.E. CASE NO. 65 12708					
1. NAME OF DECEASED (Type or Print) BESSIE JACKSON				2. DATE AND HOUR OF DEATH 12/11/65 8:37 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY 16-06			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 930 N. Rosedale St #16			
5. SEX F	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-19-23	9. AGE (In years last birthday) 42	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME Beatrice Prescott			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-25-5039		17. INFORMANT Woodrow Jackson		ADDRESS 930 Rosedale St.	
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO CVA R/O brain tumor (B) DUE TO Hypertensivetherosclerotic vascular disease (C) Chronic anemia		INTERVAL BETWEEN ONSET AND DEATH 41 days 2 yrs ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia, bilateral							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/4 19 65 to 12/11 19 65 , that (I) (we) last saw the deceased alive on 12/11 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Florahaida Reroma M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/11/65	
23C. PHYSICIAN'S NAME (Type) Florahaida Reroma				23D. ADDRESS LUTHERAN HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-16-65		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. PK		24D. LOCATION (City, town, or county) (State) Arbutus, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 14 1965		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR George H. ...		ADDRESS 1318 N. Calhoun St	

3-19-23

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										Registered No. 65 12709
BIRTH NO. 65 12709										
M.E. CASE NO.										
1. NAME OF DECEASED (Type or Print) ALMA A. JONES					2. DATE AND HOUR OF DEATH 12/8/65 1:05 A M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 16-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1143 NORTH CAREY STREET					
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 12-20-96	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Greenville S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME ANSEL ARNOLD					14. MOTHER'S MAIDEN NAME NANNIE L. DYLE					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Charles W. Jones-1143 N. Carey St.			ADDRESS			
18. 15-3, 8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Colon carcinoma metastases DUE TO (B) _____ DUE TO (C) _____			INTERVAL BETWEEN ONSET AND DEATH 1 year		
<div style="display: flex; justify-content: space-between;"> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">MEDICAL CERTIFICATION</div> <div> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> </div> </div>										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/24 19 65 to 12/8 19 65 , that (I) <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/7 19 65 and that in (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (We) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.										
23A. SIGNATURE William B. Cutts					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 12/8/65		
23C. PHYSICIAN'S NAME (Type) WILLIAM B. CUTTS					23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/12/65		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Pk.		24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland				
25A. DATE REC'D BY HEALTH DEPT. DEC 14 1965		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Herbert E. Nutter		ADDRESS 3035 W. North Ave				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 12710</u>	
BIRTH NO. <u>65 12710</u>		CERTIFICATE OF DEATH			
M.E. CASE NO. <u>65 12710</u>					
1. NAME OF DECEASED (Type or Print) <u>BIDDLE, Grant Elsworth</u>		2. DATE AND HOUR OF DEATH <u>12/11/65</u>		1:55 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Veterans Administration Hospital</u> <u>3900 Loch Raven Blvd.</u> <u>Baltimore, Maryland 21218</u>		A. STATE <u>Maryland</u> B. COUNTY <u>16-05</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>1036 N. Bentalou St.</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>5/23/95</u>	9. AGE (In years last birthday) <u>70</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown - Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Unknown - Postal Employee</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Grant E. Biddle, Sr.</u>			
14. MOTHER'S MAIDEN NAME <u>Annie Jackson</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes 10/27/17 to 3/6/19</u>			
16. SOCIAL SECURITY NO. <u>579-38-2769</u>		17. INFORMANT <u>Records: V.A. Hospital, Baltimore, Md. 21218</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Adenocarcinoma of Right Main Stem Bronchus with Carcinomatosis</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>6 Months</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>October 20</u> 19 <u>65</u> to <u>December 11</u> 19 <u>65</u> , that <u>XX</u> (we) last saw the deceased alive on <u>December 11</u> , 19 <u>65</u> and that in <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) <u>not</u> view the body after death.					
23A. SIGNATURE <u>Anna R. Berky</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12/11/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Anna R. Berky</u>		23D. ADDRESS M.D. <u>V.A. Hospital, Baltimore, Md. 21218</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/15/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arlington Natl. Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Ft. Myer Va.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 14 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Herbert E. Nutter-3035 W. North Ave</u>	

... ..
... ..
... ..

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... ..
... ..
... ..
... ..

BIRTH NO.

65 12711

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 12711

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WYLIE F. SHAW

2. DATE AND HOUR PRONOUNCED DEAD

12-5-65

4:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

517 SHARP STREET

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

22-01

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

517 Sharp Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

10-28-1918

9. AGE (In years
last birthday)

47

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

237-10-0867

17. INFORMANT

ADDRESS

Alice Shaw 1016 Augustus

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Fatty liver

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Chronic ethylism

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-6-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/9/65

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

Baltimore

MD.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Aslington S. Phillips 1727 N. Mount

WALKER FORCE

NO. 100

Report on the
the
the
the

100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12712	
BIRTH NO. 65 12712		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Johnnie John Edward Green		12-9-65 8:25 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital		A. STATE MARYLAND B. COUNTY 10-02	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 803 Somerset Street	
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH 5-1-06
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) 59	11. BIRTHPLACE (State or foreign country) Virginia
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nelson Green		14. MOTHER'S MAIDEN NAME ANNA Foster	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 223-28-4289	
		17. INFORMANT ADDRESS Bessie Mickey 2511 Bells Rd. Richmond, Va.	
18. 434.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute pulmonary edema		CAUSE OF DEATH (A) DUE TO Acute pulmonary edema	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Digitalis toxicity		(B) DUE TO Digitalis toxicity	
		(C) _____	
INTERVAL BETWEEN ONSET AND DEATH 1 week			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At <input type="checkbox"/> Work At Work	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12-6-1965 to 12-9-1965 , that (I) (we) lost saw the deceased alive on 12-9-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Frank L. Barham MD		23B. DATE SIGNED 12-9-65	
23C. PHYSICIAN'S NAME (Type) FRANK L. BARHAM		23D. ADDRESS M.D. Mercy Hospital, Balto., MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal	24B. DATE 12-10-1965	24C. NAME OF CEMETERY or CREMATORY Rose Land Cemetery	24D. LOCATION (City, town, or county) (State) Richmond, Virginia
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS Dabney Funeral Home Ashland, Virginia	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No.	
65 12713		235164				65 12713	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Davenport, Morris</i>			
2. DATE AND HOUR OF DEATH <i>12/6/65</i> <i>5:50 P.M.</i>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>15-38</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Sinai Hospital</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
D. STREET ADDRESS (If rural, give location) <i>2404 Elinor Ave.</i>							
5. SEX <i>M</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>12/3/1883</i>	9. AGE (In years last birthday) <i>82</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Alabama</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Mary S. Farley 1837 W. Saratoga</i>			
18. <i>492X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Uremia, cont.</i>				CAUSE OF DEATH <i>Pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12/2</i> 19 <i>65</i> to <i>12/6</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>12/6</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Leonard J. Kautsky</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>12/6/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Leonard J. Kautsky, M.D.</i>				23D. ADDRESS <i>Sinai Hospital Baltimore</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/11/65</i>		24C. NAME of CEMETERY or CREMATORY <i>Arbutus Mem. Lk. Baltimore</i>		24D. LOCATION (City, town, or county) (State) <i>MD.</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>965001</i>		25C. FUNERAL DIRECTOR <i>William J. Phillips</i>		ADDRESS <i>172717 Monaca</i>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 12714	
BIRTH NO. 65 12714		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) David Jones		2. DATE AND HOUR OF DEATH 12-12-65 12:25AM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Provident Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 1211 North Stricker Street			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, Maryland 16-02			
D. STREET ADDRESS (If rural, give location)							
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2-21-08	9. AGE (In years last birthday) 47	10. Under 1 Yr. Months: Days:	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Sta. Attnd			10B. KIND OF BUSINESS OR INDUSTRY Gas Station		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Minnie Smith 1104 Leadenhall St		
18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH Massive Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0 None				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) XXX				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) HOME	
21D. TIME OF INJURY (APPROX.) XXXXXXXX 12:00 PM				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? fell at work, brought to hospital	
22. I certify that (I) (this hospital) attended the deceased from 12-11-65 19 to 12-12-65 19, that (I) (we) last saw the deceased alive on 12-12-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12. 12. 65	
23C. PHYSICIAN'S NAME (Type) ROGER THEODORE				23D. ADDRESS 1514 Division Street, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/15/65		24C. NAME OF CEMETERY or CREMATORY Baltimore, National Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR I. L. BROWN & SON		ADDRESS 123 W. Montgomery St.	

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Handwritten text, possibly a signature or name, appearing in the center of the page.

Handwritten text, possibly a signature or name, appearing in the lower right quadrant.

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

65 12715

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12715

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MAGGIE JO WILLIAMS

2. DATE AND HOUR PRONOUNCED DEAD

12-5-65

5:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

428 E. 20th Street 21218

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

77 July 1, 1895 70

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Domestic

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Unk.

14. MOTHER'S MAIDEN NAME

Mary Johnson.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

428 E. 20th. St.
Mrs. Maggie Belfield, Balti. Md

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenia, etc. It means the disease,
injury or complication which caused death.)(A) Carcinoma of the cervix
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
m. WORK AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

CHAS. S. PETTY, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-6-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

11/7/65

23C. NAME OF CEMETERY or CREMATORY

Gaston Church Cem.

23D. LOCATION

(City, town, or county)

(State)

Near Gaston, N. C.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 14 1965

Isaiah L. Brown & Son
108 W. 2nd Montgomer y ST.

70 1,1 1,1 1,1

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

John MORRISSEY

2. DATE AND HOUR PRONOUNCED DEAD

Dec. 11, 1965

6:22 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
MarylandB. COUNTY
Middle River

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Middle River

D. STREET ADDRESS (If rural, give location)

1827 Wilson Point Rd.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

4-29-1904

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

WELDER

10B. KIND OF BUSINESS OR INDUSTRY

UNITEC Co.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN JOSEPH MORRISSEY

14. MOTHER'S MAIDEN NAME

ANNA M. PHILLIPS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

N.W. II

16. SOCIAL
SECURITY NO.

213-07-4396

17. INFORMANT

ADDRESS

Mrs. Christina Byrd Morrissey - 1827 Wilson Pt. Rd.

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) ~~DECEASED~~ Arteriosclerotic cardiovascular
disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Dec. 12, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

12-15-65

23C. NAME OF CEMETERY or CREMATORY

HOLY REDEEMER Cem.

23D. LOCATION

(City, town, or county)

(State)

BALTO., MD.

24A. DATE REC'D BY HEALTH DEPT.

DEC 14 1965

24B. NAME OF REGISTRAR

Robert E. Spitz

24C. FUNERAL DIRECTOR

ADDRESS

J. Spitz - 2334 Jefferson St.

Handwritten signature and the word "HAWAII" in capital letters.

CERTIFICATE OF DEATH

Registered No. 65 12717

BIRTH NO.

65 12717

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Agnes V. Biedenbach

2. DATE AND HOUR OF DEATH

12-14-65 4:50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)
645 Dunwich Way 21221

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

1-7-1916

9. AGE (In years
last birthday) 49If Under 1 Yr.
Months: Ooys:If Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

TAILORING

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Harry Schaeck SCHAECK

14. MOTHER'S MAIDEN NAME

Mamie MAMIE SUNDERLAND

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18.

153.31

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Carcinoma of the
DUE TO colon (sigmoid)

1961

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At ☐ Not While
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-6 1965 to 12-14 1965
that (I) (we) last saw the deceased alive on 12-14 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

12-14-65

23C. PHYSICIAN'S
NAME (Type)

Jeffrey D. Aaronson

23D. ADDRESS

M.D. 4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

12-17-65

24C. NAME OF CEMETERY or CREMATORY

GARDENS OF FAITH

24D. LOCATION

(City, town, or county)

(State)

BALTO., MD.

25A. DATE REC'D BY HEALTH DEPT.

DEC 14 1965

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

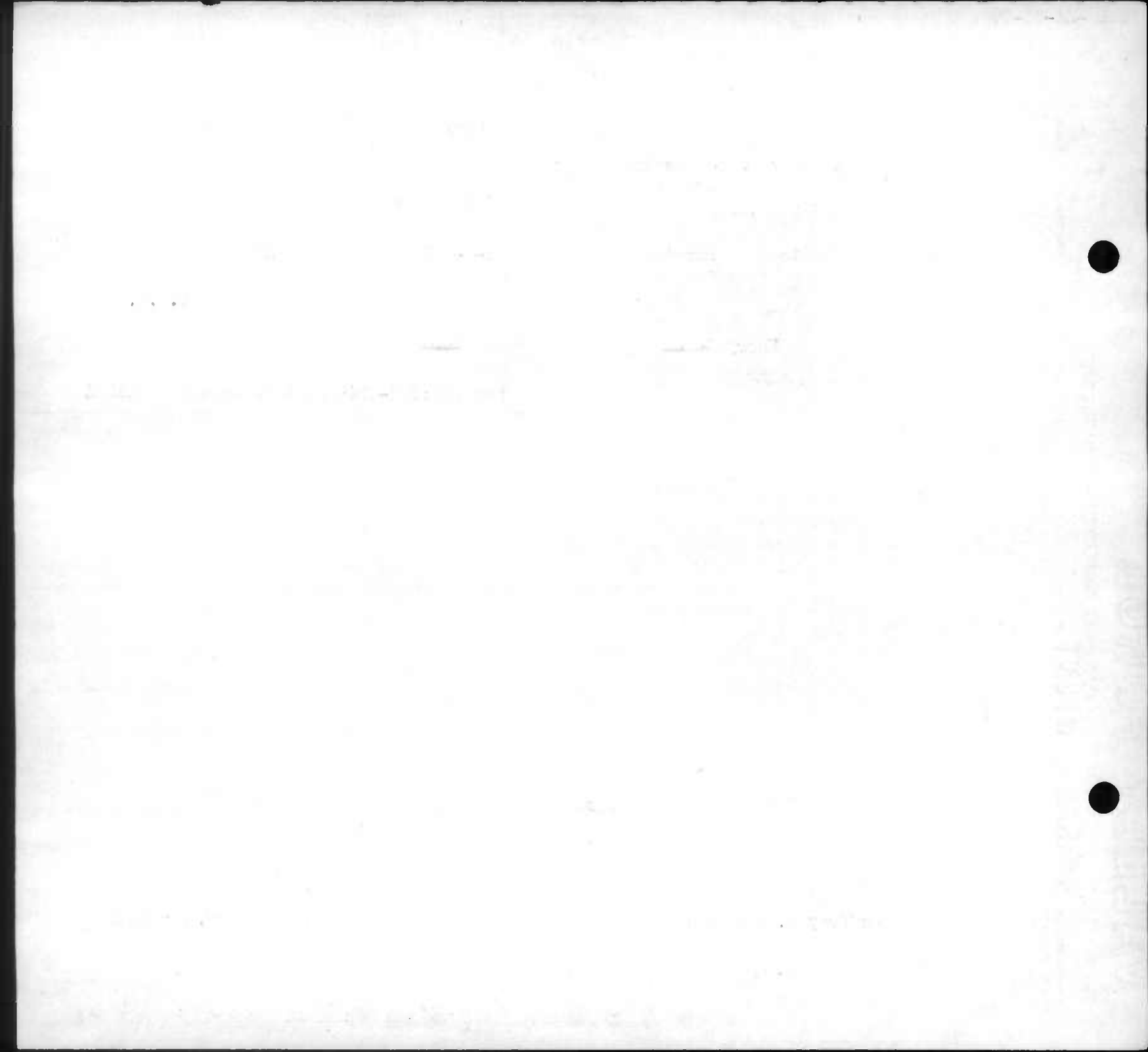
ADDRESS

2334 Jefferson St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B.351



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12718	
BIRTH NO. 65 12718		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Dembeck, James John		2. DATE AND HOUR OF DEATH 12/12/65 7:30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Montebello State Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 26-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3419 Clifftmont Ave.			
5. SEX male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 4/25/1903	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10B. KIND OF BUSINESS OR INDUSTRY Ship Yard, Bethleh.		11. BIRTHPLACE (State or foreign country) Maryland, Baltimore	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Dembeck		14. MOTHER'S MAIDEN NAME Ida unknown JANKOWSKA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-09-6535		17. INFORMANT John P. Dembeck 3419 Clifftmont Ave.	
18. 581.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cirrhosis of Liver DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 5 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/12/65 to 12/12/65 that (I) (we) last saw the deceased alive on 12/12/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel G. Lai		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/12/65	
23C. PHYSICIAN'S NAME (Type) Daniel G. Lai		23D. ADDRESS 2201 Argonne Drive, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/16/65		24C. NAME OF CEMETERY or CREMATORY Holy Cross Cem German Hill Rd Baltimore, Maryland	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. DEC 14 1965			
25B. NAME OF REGISTRAR Robert E. Talley, M.D.		25C. FUNERAL DIRECTOR Dippel Brothers Inc 1800 E. Lombard St.			

1941

1941

1941

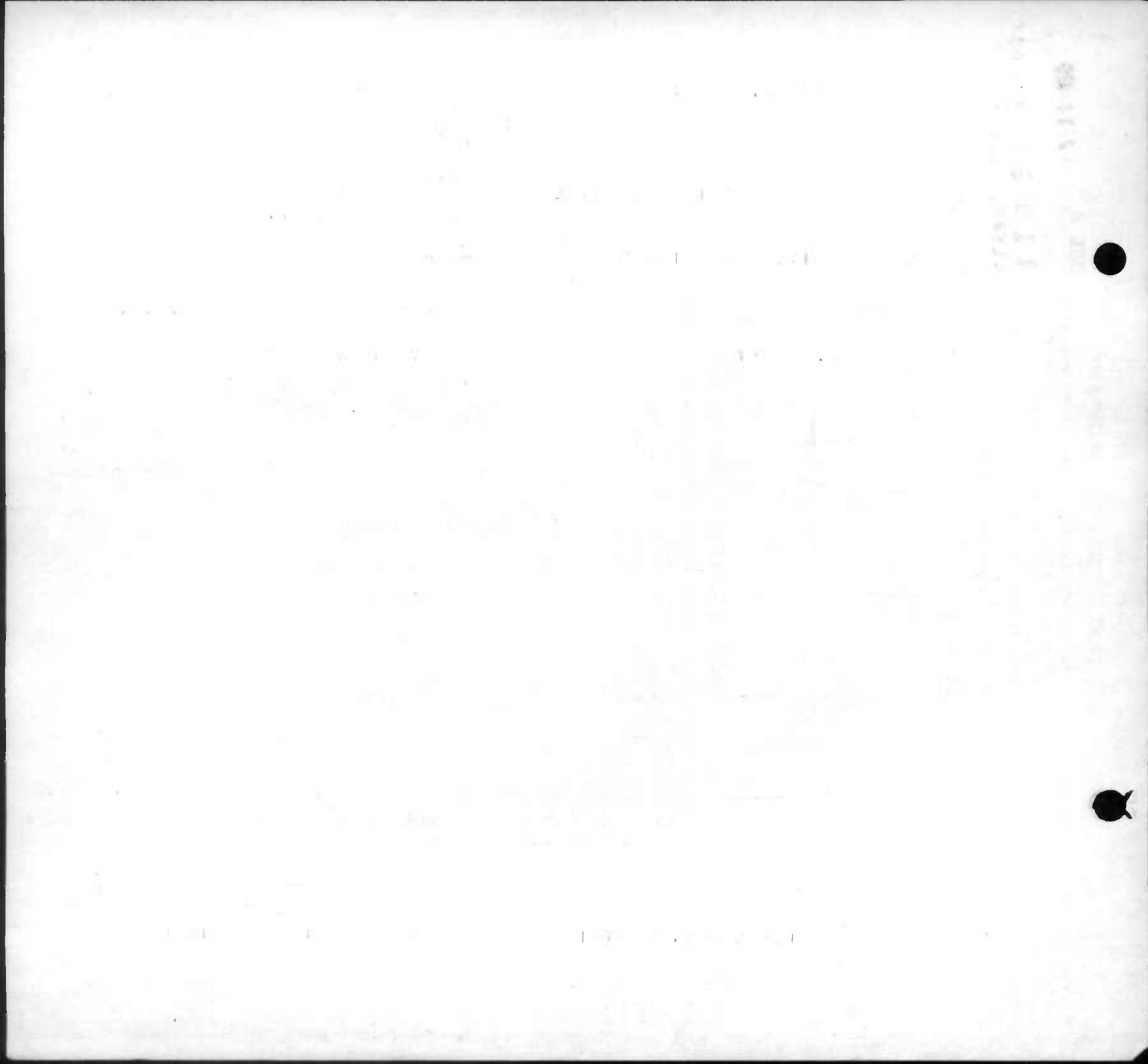
1941

1941

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>65 12719</u>	
BIRTH NO. <u>65 12719</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>JOHN T. OLERT</u>		2. DATE AND HOUR OF DEATH <u>12-12-65</u> <u>10:00</u> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>THE JOHNS HOPKINS HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>9-9</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>1430 HOLBROOK ST.</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>DIVORCED</u>	8. DATE OF BIRTH <u>3-23-03</u>	9. AGE (In years last birthday) <u>62</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>GEORGE J. OLERT</u>			14. MOTHER'S MAIDEN NAME <u>MARY STREB</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes World War #2 543 24 5273</u>			16. SOCIAL SECURITY NO. <u>5000 6 Lodes Tone Way 21206</u>		17. INFORMANT <u>Mrs Ethel L. Hensley</u>		
18. <u>393X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute Renal Failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Unknown cause</u>				CAUSE OF DEATH (A) <u>Acute Renal Failure</u> DUE TO (B) <u>Unknown cause</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Lactic acidosis</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12-10</u> 19 <u>65</u> to <u>12-12</u> 19 <u>65</u> , that (I) (we) lost saw the deceased alive on <u>12-12</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE <u>Nicholas J. Fortuin</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12-12-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>NICHOLAS J. FORTUIN</u>				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/15/65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 14 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Jaffee</u>		25C. FUNERAL DIRECTOR <u>HENRY SANDER & SONS INC.</u>		ADDRESS <u>BALTIMORE MARYLAND</u>	



BIRTH NO.

65 12720

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 12720

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Myrtle LEWIS

2. DATE AND HOUR PRONOUNCED DEAD

Dec. 12, 1965

12:28 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

808 Leadenhall Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

W

8. DATE OF BIRTH

12-31-1902

9. AGE (In years
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Glass Factory

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Walter Broadley

14. MOTHER'S MAIDEN NAME

Ida Kellman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

808 Leadenhall St * Roland Broadley

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Acute 2nd° thermal burns over 70% of
body surface.INTERVAL BETWEEN
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Acute alcohol intoxication

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

808 Leadenhall Street, Baltimore

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
Dec. 12, 1965 ?

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

scalded self in bath tub

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Dec. 12, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

Burial

12-16-65

Mt Auburn Cemetery

Baltimore, City

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 14 1965

Robert E. Spitz, M.D.

Isaiah L. Brown and Son

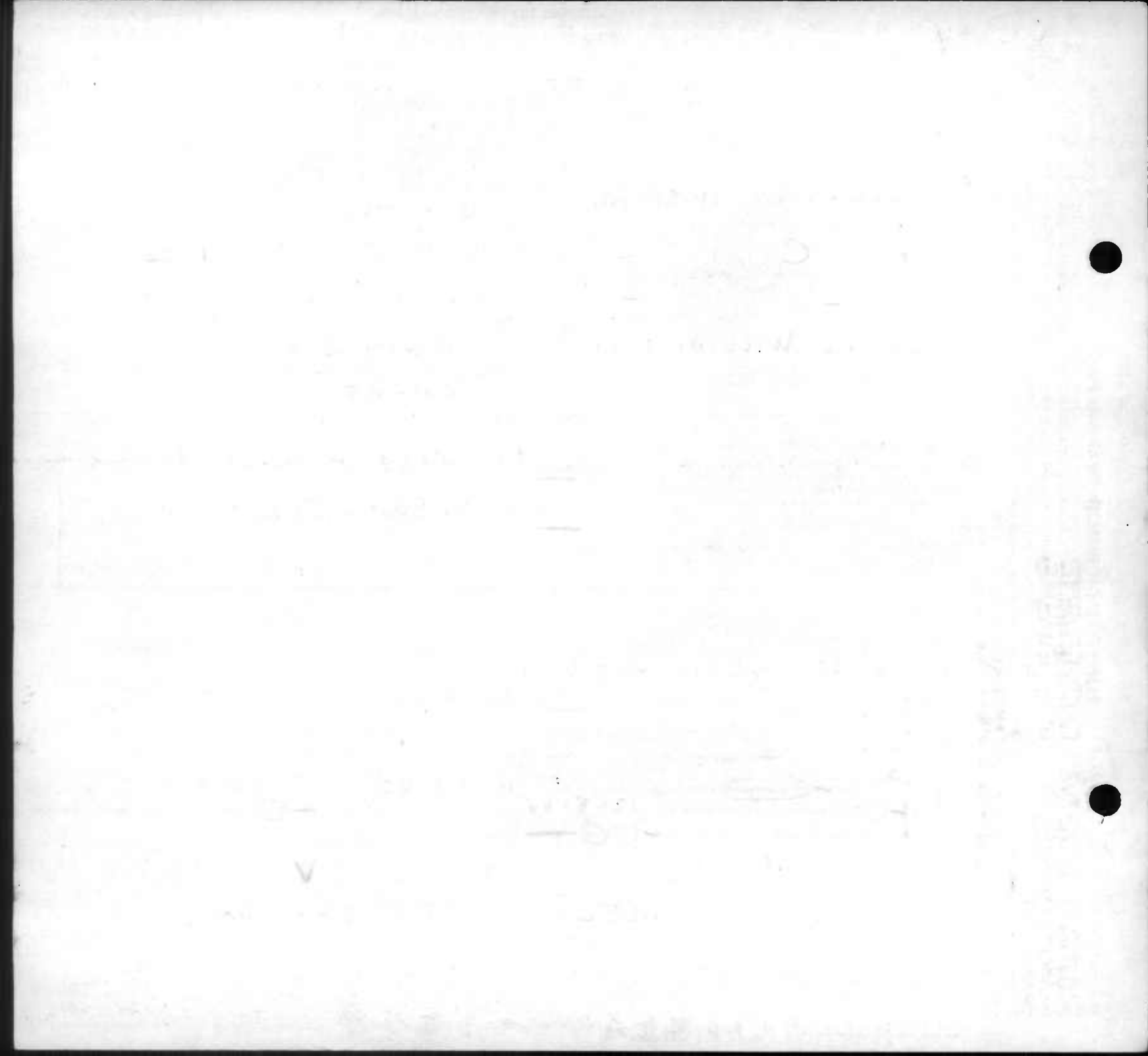
108 W. Montgomery Street

WALLEY PHOTO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12721	
BIRTH NO. 65-26543 65 12721		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Cynthia SCOTT			
2. DATE AND HOUR OF DEATH		12-8-65 5.50 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
UNIVERSITY HOSPITAL		MD.			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Severna Park 6200			
		D. STREET ADDRESS (If rural, give location)			
		Box 420.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days 1 20
F	C	—	10-19-65		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
—		—		MARYLAND	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
JAMES WILLIAMSON			Mary SCOTT		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				CHART-	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) TRICUSPID ATRESIA		1 month 20 days	
ANTECEDENT CAUSES		(B) Ventricular Septal Defect		1 month 20 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
11-8-65		Congenital Heart Disease			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (H) (this hospital) attended the deceased from 10-29-65 19 to 12-8-65 19, that (H) (we) last saw the deceased alive on 12-8-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Carlos Abel				12-8-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
CARLOS ABEL		UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		12-10-65		CARPENTER'S HILL	
				Severna Park-Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 14 1965		C. E. Hicks III		ANNAPOLIS - Md.	



BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65-12722

1. NAME OF DECEASED
(Type or Print)

LETHEL CABARIES

2. DATE AND HOUR PRONOUNCED DEAD

November 24, 1965

9:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2513 Emerson Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2513 Emerson Street

5. SEX

male

6. RACE

negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

11-14-65

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.

10

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Congenital heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about)
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenacker, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-24-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH/DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 14 1965

WALLACE P. GURDIE

Completed by Mrs. J. M. Gurdie

DEC 14 1933

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. B-652		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12723	
M.E. CASE NO. 65 12723		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ISABELLE BRINK		2. DATE AND HOUR OF DEATH 12-6-65 4:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3902 SOUTHERN AVENUE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 8-19-77	9. AGE (in years last birthday) 88	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS RECORDS: BCH-4940 EASTERN AVE. - #21224		
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Pneumonia DUE TO (B) CVA DUE TO (C) ASCVD		INTERVAL BETWEEN ONSET AND DEATH 2 mrs. 24. 10y.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Meloma					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/25 19 65 to 12/6 19 65 , that (I) (we) last saw the deceased alive on 12/6 19 65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. Moravec		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/6/65	
23C. PHYSICIAN'S NAME (Type) DR. C. MORAVEC		23D. ADDRESS MD 4940 EASTERN AVENUE #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) DEC 14 1965		24B. NAME OF CEMETERY OF CREMATORY ANATOMY BOARD OF MARYLAND		24D. LOCATION (City, town, or county) (State) UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT. DEC 14 1965		25B. NAME OF REGISTRAR Robert E. Fagan		25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCHD	

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1

65 12724

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12724

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES KOHLER

2. DATE AND HOUR PRONOUNCED DEAD

December 1, 1965

1:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

920 N. Calvert Street

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-1-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

DEC 14 1965

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 14 1965

MORTUARY SERVICE

BCHD

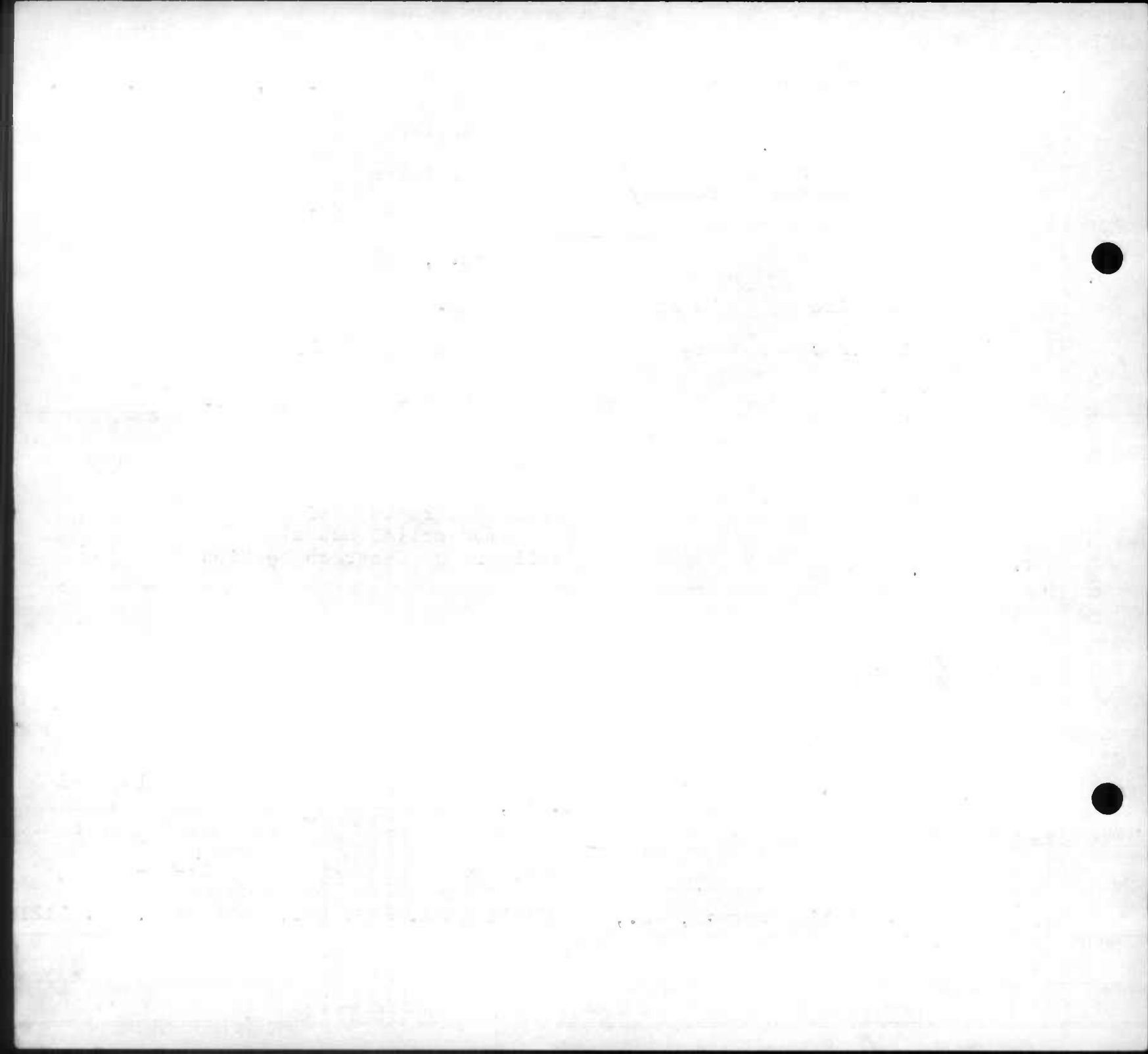
WALTER BORGIS

IN CHARGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

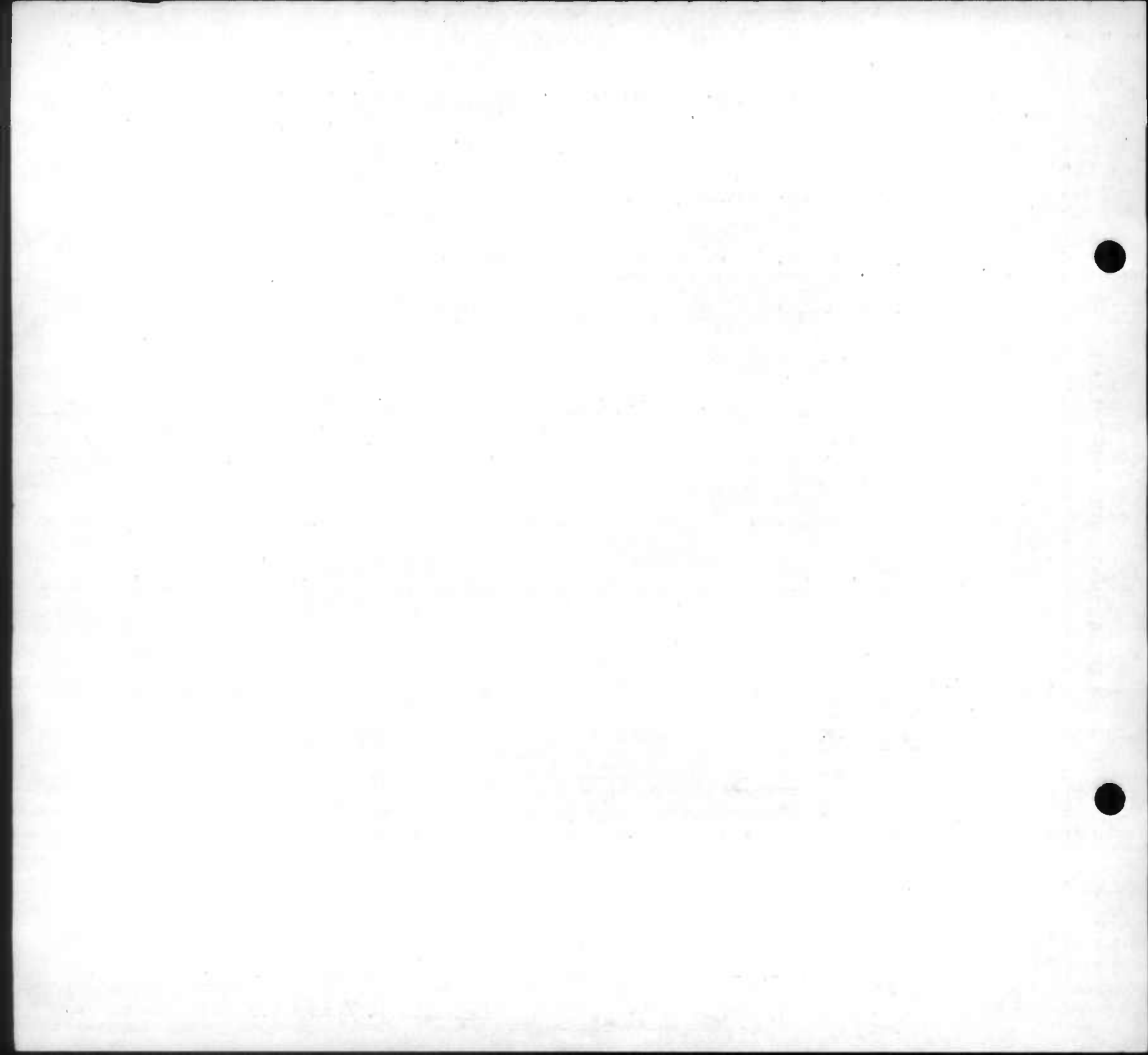
BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. 65 12725					
BIRTH NO. 65 30660		65 12725								
M.E. CASE NO.					2. DATE AND HOUR OF DEATH					
1. NAME OF DECEASED (Type or Print) BABY BOY HENRY					Dec. 10, 1965 7.30 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital Fayette & Broadway					A. STATE Maryland					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					
					D. STREET ADDRESS (If rural, give location) 601 Cator Ave.					
5. SEX M	6. RACE W	7. MARRIED, <u>NEVER MARRIED</u> WIDOWED, DIVORCED (specify)			8. DATE OF BIRTH Dec. 9, 1965	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY Home			11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Richard James Henry					14. MOTHER'S MAIDEN NAME Marlene Mihalik					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) XXX			16. SOCIAL SECURITY NO. XXX		17. INFORMANT Mother - 601 Cator Ave.			ADDRESS		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					(A) Hyaline membrane disease DUE TO			INTERVAL BETWEEN ONSET AND DEATH 8 hours		
					(B) Premature rupture of membranes (48 hours) DUE TO					
					(C) Delivery by Cesarean section					
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 12-9-65 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Delivery 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					
					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					
					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
					21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					
21E. INJURY OCCURRED					21F. HOW DID INJURY OCCUR?					
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>										
22. I certify that (I) (this hospital) attended the deceased from December 9, 1965 to December 10, 1965 , that (I) (we) last saw the deceased alive on Dec. 10, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <i>J. William Dorman Jr., M.D.</i>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 12-10-65		
23C. PHYSICIAN'S NAME (Type) J. William Dorman, Jr.,					23D. ADDRESS 3101 St. Paul St., Baltimore, Md. 21218					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE DEC 14 1965		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) UNIVERSITY MEDICAL SCHOOL				
25A. DATE REC'D BY HEALTH DEPT. DEC 14 1965			25B. NAME OF REGISTRAR <i>Robert E. ...</i>			25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD			ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

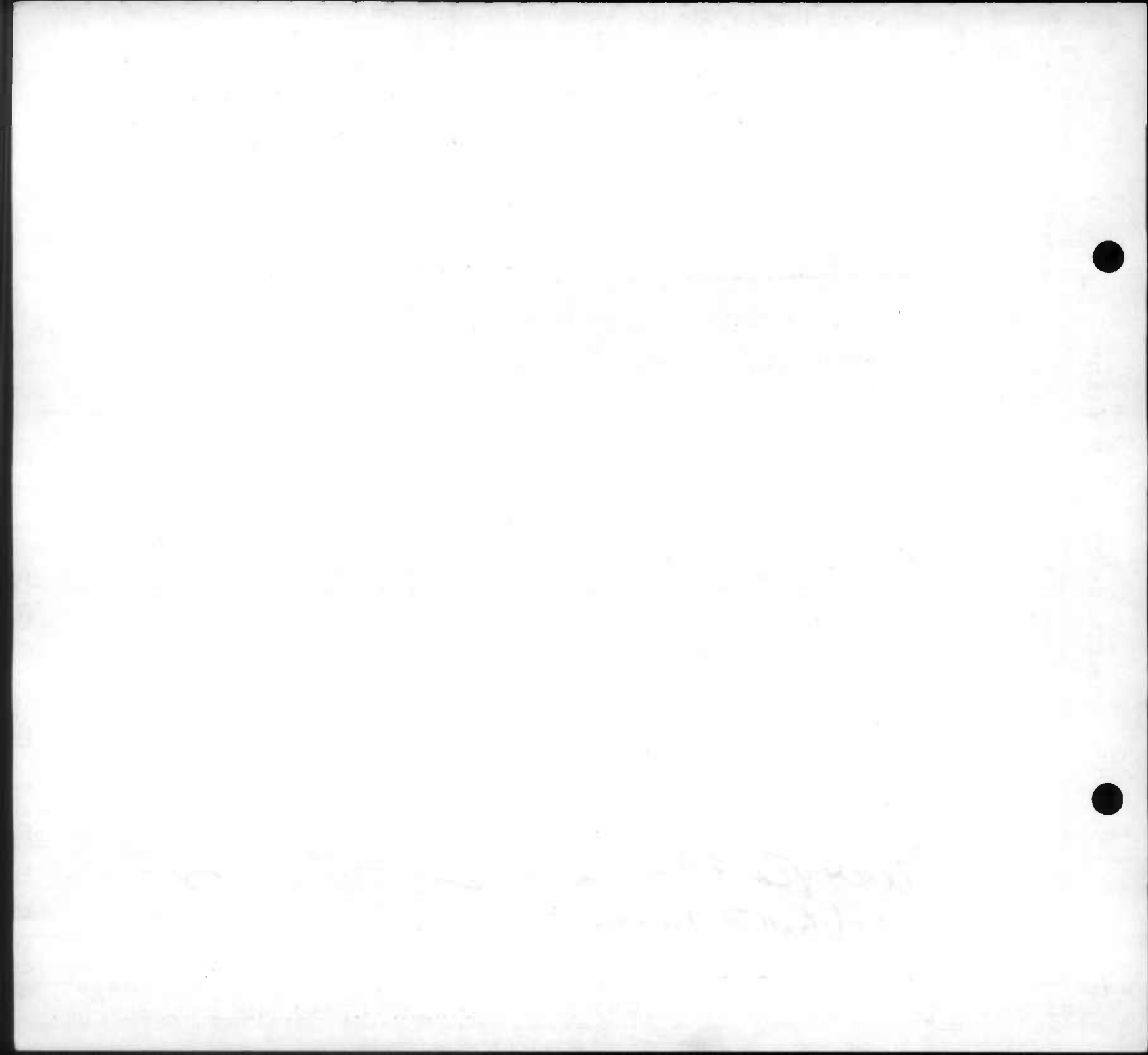
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>65 12726</u>				
BIRTH NO. <u>65 12726</u>					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <u>Harry L. Parrott, Sr.</u>					2. DATE AND HOUR OF DEATH <u>Dec. 12, 1965</u> <u>11 A.M.</u>				
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>26-03</u>				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Harford Gardens Nursing Home</u>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>				
D. STREET ADDRESS (If rural, give location) <u>3569 Shannon Drive</u>									
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED <u>widowed</u>	8. DATE OF BIRTH <u>July 13, 1879</u>	9. AGE (In years last birthday) <u>86</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Machinist</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Henry Clay Parrott</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Wood</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>214079562</u>		17. INFORMANT <u>Mrs Almeta Morgan</u>		ADDRESS <u>same</u>		
18. <u>332X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Right Cerebral Thrombosis</u> (A) DUE TO					INTERVAL BETWEEN ONSET AND DEATH <u>17 hours</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Generalised Arteriosclerosis</u> (B) DUE TO					?				
(C) _____									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (<u>Mrs</u> hospital) attended the deceased from <u>12-11-1965</u> to <u>12-12-1965</u> , that (I) (<u>we</u>) lost saw the deceased olive on <u>12-11-1965</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (did) (<u>did not</u>) view the body after death.									
23A. SIGNATURE <u>Milton C. Lang</u>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>12-13-65</u>		
23C. PHYSICIAN'S NAME (Type) <u>Milton C. Lang</u>					23D. ADDRESS M.D. <u>2117 Belair Rd 21213</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>12-15-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 14 1965</u>		25B. NAME OF REGISTRAR <u>Robert J. Ruck</u>			25C. FUNERAL DIRECTOR <u>Lepard J. Ruck Inc Baltimore, Md.</u>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

65 12727		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12727	
BIRTH NO.		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Joseph Sienkielewski</i>			2. DATE AND HOUR OF DEATH <i>December 10, 1965</i> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Baltimore City Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>902</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>1601 Argonne Drive</i>		
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>Feb. 20, 1887</i>	9. AGE (In years last birthday) <i>78</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Self Employed</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Poland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			13. FATHER'S NAME <i>Not known</i>		
14. MOTHER'S MAIDEN NAME <i>Not known</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		
16. SOCIAL SECURITY NO.			17. INFORMANT <i>Wanda Sienkielewski</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>420.11</i>			CAUSE OF DEATH (A) DUE TO <i>S. C. D. - can -</i> (B) DUE TO <i>General Heart Disease</i> (C) _____		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/10/65</i> 19 to <i>12/10/65</i> 19, that (I) (we) last saw the deceased alive on <i>12/11/65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Wanda Sienkielewski</i> M.D.			23B. DATE SIGNED <i>12/12/65</i>		
23C. PHYSICIAN'S NAME (Type) <i>Wanda Sienkielewski</i> M.D.			23D. ADDRESS <i>1601 Argonne Drive</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>12-14-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Woodlawn Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 14 1965</i>			
25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc Baltimore, Md.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
65 12728					CERTIFICATE OF DEATH					Registered No. 65 12728									
BIRTH NO.										M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <i>Albert W. Finnegan</i>										2. DATE AND HOUR OF DEATH <i>Dec. 12, 1965</i> <i>7.40 A</i> M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION <i>316 Birkwood Place</i>										A. STATE <i>Md.</i> B. COUNTY <i>Balto</i>									
5. SEX <i>male</i> 6. RACE <i>white</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>										8. DATE OF BIRTH <i>4-21-1898</i> 9. AGE (In years last birthday) <i>67</i>									
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Race Track Employee</i>										11. BIRTHPLACE (State or foreign country) <i>Maryland</i>									
13. FATHER'S NAME <i>Lawrence Finnegan</i>										14. MOTHER'S MAIDEN NAME <i>Susan Ward</i>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>										16. SOCIAL SECURITY NO. <i>212093969</i>									
17. INFORMANT <i>Dorothea N. Finnegan</i>										ADDRESS <i>same</i>									
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Thrombosis</i>										INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i>									
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Arteriosclerotic coronary artery disease with infarction</i>										<i>1958</i>									
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes mellitus</i>										<i>2 years</i>									
19A. DATE OF OPERATION										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)										21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)									
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)										21D. TIME OF INJURY (Month) (Day) (Year) (Hour)									
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>										21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from <i>August 15</i> 19 <i>53</i> to <i>December 12</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>December 12</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE <i>E. J. Alessi</i>										23B. DATE SIGNED <i>12/13/65</i>									
23C. PHYSICIAN'S NAME (Type) <i>E. J. Alessi M.D.</i>										23D. ADDRESS <i>6217 Harford Rd. Balto. Md.</i>									
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>										24B. DATE <i>12-15-65</i>									
24C. NAME OF CEMETERY or CREMATORY <i>Baltimore Cemetery</i>										24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>									
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 14 1965</i>										25B. NAME OF REGISTRAR <i>Leonard J. Ruck</i>									
25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc</i>										ADDRESS <i>Baltimore, Md.</i>									

The present document
contains the original
of the letter of the
1st of June 1864

1864
June 1st

B. J. J.

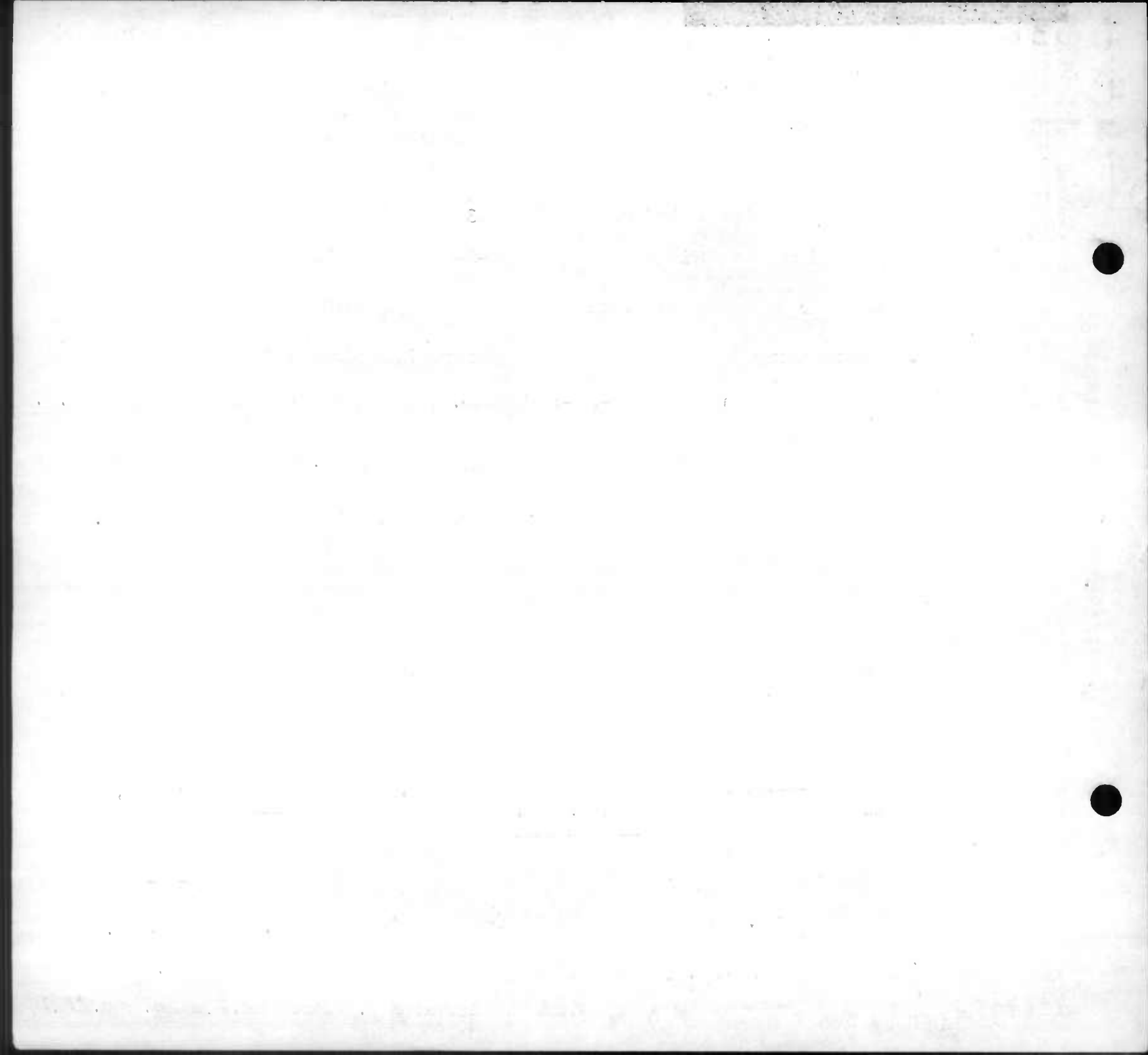
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **65 12729**

BIRTH NO. 65-12729		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) Olive Anderson		2. DATE AND HOUR OF DEATH 12-13-65 8:25 am.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1301 Rayleigh Way	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 7-2-04
9. AGE (In years last birthday) 61		10. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME J. Thomas Gray		14. MOTHER'S MAIDEN NAME Sarah Ann Blackford	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 206-10-1609	
17. INFORMANT Mrs. Jesse Gabbert, Long Island, N.Y.		ADDRESS	
18. 464X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Probable pulmonary embolus ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Deep thrombophlebitis		INTERVAL BETWEEN ONSET AND DEATH sudden 4 weeks.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from December 2, 1965 to December 13, 1965 , that (I) (we) last saw the deceased alive on December 12, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Jay B. Jensen M.D.		23B. DATE SIGNED 12-13-65	
23C. PHYSICIAN'S NAME (Type) Jay B. Jensen		23D. ADDRESS M.D. Johns Hopkins Hospital, Baltimore, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/16/65	
24C. NAME OF CEMETERY or CREMATORY Forest Home Cemetery		24D. LOCATION (City, town, or county) (State) Taylor, Pa.	
25A. DATE REC'D BY HEALTH DEPT. DEC 14 1965		25B. NAME OF REGISTRAR Leonard J. Ruck Inc. Balto. Md. 21214	
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214		ADDRESS	

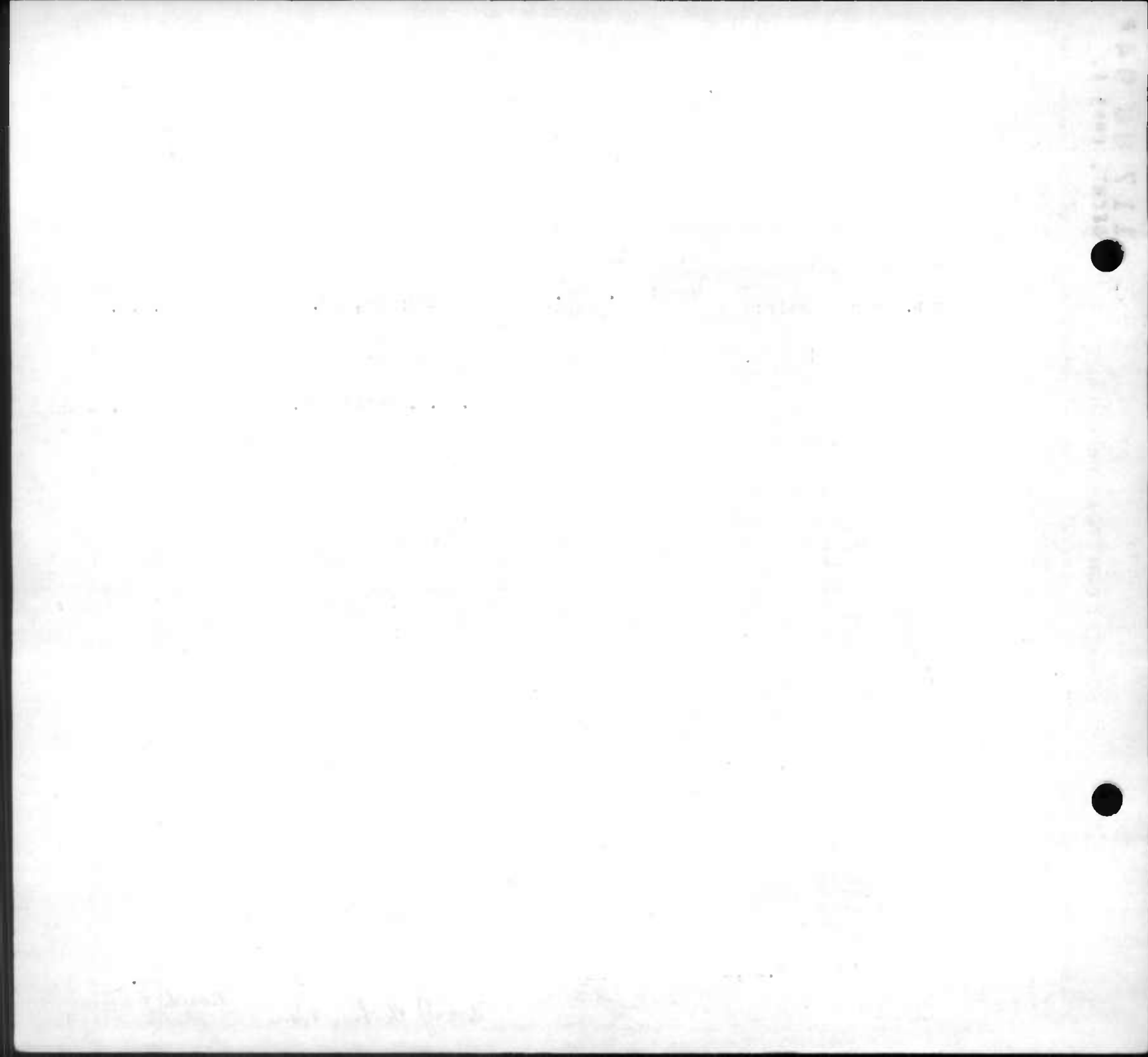


11788941
HECHT, EMMA R.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

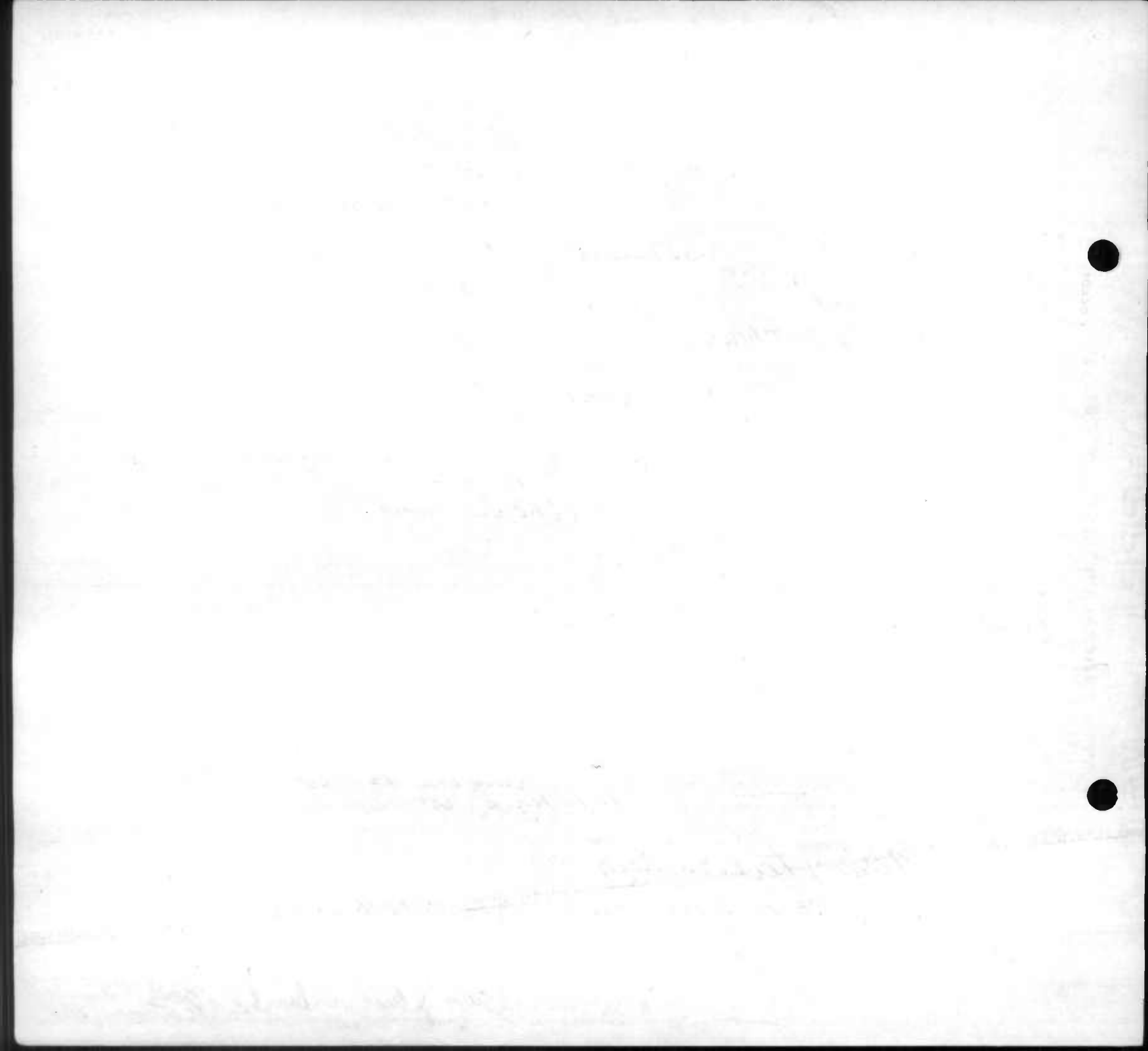
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12730	
BIRTH NO. 65 12730		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) EMMA R. HECHT		12-11-65 5.30 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND B. COUNTY 28-41			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		D. STREET ADDRESS (If rural, give location) 4401 GROVELAND AVENUE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 11-10-13	9. AGE (In years last birthday) 52	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Buyer Retired		10B. KIND OF BUSINESS OR INDUSTRY Hecht Co. Dept. Stores		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM H. RANSLEY			
14. MOTHER'S MAIDEN NAME LILIAM E. PIPER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Wm. H. Ransley Jr. 2800 Bayonne Ave. 21214			
18. 154X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Carcinoma rectum, metastatic DUE TO (B) Respiratory Insufficiency DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 11-15-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma rectum		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-11-65 19 to 12-11-65 19, that (I) (we) last saw the deceased alive on 12-11-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph Rich		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-11-65	
23C. PHYSICIAN'S NAME (Type) JOSEPH RICH		23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 14, 1965		24C. NAME OF CEMETERY or CREMATORY Woodlawn	
24D. LOCATION Woodlawn		24E. (City, town, or county) Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 14 1965		25B. NAME OF REGISTRAR Robert J. ...		25C. FUNERAL DIRECTOR Wm. J. ...	
25D. ADDRESS North ...		25E. ...			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12731	
65 12731				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>SANDRA MATTHEWS</i>				<i>December 10, 1965</i> 6 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <i>Montebello State Hospital</i>			A. STATE <i>MARYLAND</i> B. COUNTY <i>25-33</i>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore, Md.</i>		
			D. STREET ADDRESS (If rural, give location) <i>2828 MAISEL ST.</i>		
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Never Married</i>	8. DATE OF BIRTH <i>4-17-48</i>	9. AGE (In years last birthday) <i>17</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>unemployed</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
13. FATHER'S NAME <i>Charles Matthews</i>			14. MOTHER'S MAIDEN NAME <i>DORIS ASHLEY</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT ADDRESS <i>Hospital Chart -</i>		
18. <i>759.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>Epidermolysis Bullosa Distro-</i> DUE TO <i>phica -</i> (B) <i>Unknown cause -</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>17 years</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>None -</i>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>November 12 19 65</i> to <i>December 10 19 65</i> , that (I) (we) last saw the deceased alive on <i>December 10 19 65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Cesar J. Pellerano</i> M.D.				23B. DATE SIGNED <i>December 10, 1965</i>	
23C. PHYSICIAN'S NAME (Type) <i>CESAR J. PELLERANO</i>				23D. ADDRESS <i>% Montebello State Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/14/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Loudon Park Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 14 1965</i>		25B. NAME OF REGISTRAR <i>Wm. J. Pellerano</i>		25C. FUNERAL DIRECTOR <i>North & Conway Bros. Inc. Baltimore, Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 12732	
BIRTH NO. 65 12732							
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) MARGARET Naomi Stevenson		2. DATE AND HOUR OF DEATH Dec 10, 1965 10:10 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 903 Cathedral St # 1 B. COUNTY Balt MD			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY of MARYLAND HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balt MD		D. STREET ADDRESS (If rural, give location) 903 Cathedral St # 1	
5. SEX Female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 10/6/08	9. AGE (In years last birthday) 57	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERICAL WORKER			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME OSCAR PAUL COLEMAN				
14. MOTHER'S MAIDEN NAME MARY ELLEN CALLAHAN			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS HANNAH O'CONNOR 61A Fenway N.				
18. 609X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Septicemia DUE TO (B) Urinary Tract Infection DUE TO (C) Parkinson's Disease		INTERVAL BETWEEN ONSET AND DEATH 3 hours 5 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Parkinson's Disease							
19A. DATE OF OPERATION 10/19/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Parkinson's Disease		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from October 14 19 65 to December 10 19 65 , that (I) (we) last saw the deceased alive on December 10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Fuangvudhiran M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-10-65	
23C. PHYSICIAN'S NAME (Type) THAVAT CHAI FUANGVUDHIRAN M.D.				23D. ADDRESS University Hospital, Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 14, 1965		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 14 1965		25B. NAME OF REGISTRAR J. E. ...		25C. FUNERAL DIRECTOR ADDRESS W. V. ... & Sons N. & Pa. Aves			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>65 12733</u>	
BIRTH NO. <u>65 12733</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Schoff, Howard H.</u>		2. DATE AND HOUR OF DEATH <u>12/12/65</u> <u>9:15 A.M.</u>	
3. PLACE OF DEATH IN <u>Baltimore, Maryland</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>29-09</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>44 UNION MEMORIAL HOSP.</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
				D. STREET ADDRESS (If rural, give location) <u>1521 PENTRIDGE RD</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED (specify)</u>		8. DATE OF BIRTH <u>6/4/89</u>	9. AGE (In years last birthday) <u>76</u>	10. If Under 1 Yr. Months: Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman (Retired)</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Schoff</u>			
14. MOTHER'S MAIDEN NAME <u>Marie Reese</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NAK</u>			
16. SOCIAL SECURITY NO. <u>219-05-4605</u>				17. INFORMANT ADDRESS <u>Hospital records</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>451X1 SHOCK</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 h</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO <u>MYOCARDIAL INFARCTION</u> <u>10 h</u>			
(C) DUE TO <u>? Dissecting Aneurysm</u>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>4:15 AM 12/12 19 65</u> to <u>9:15 AM 12/12 19 65</u> , that <u>(H)</u> (we) last saw the deceased alive on <u>9:15 AM 12/12 19 65</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(H)</u> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>R. Whitlock</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>12/12/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>- R. Whitlock</u>				23D. ADDRESS M.D. <u>Union Memorial Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/15/65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 14 1965</u>		25B. NAME OF REGISTRAR <u>Reuben E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Wm. J. Hickman & Sons</u>		ADDRESS <u>North & Bond 21217</u>	

2000-01-01

12/15/00
12/15/00
12/15/00

UNION MEMBERSHIP

12/15/00

12/15

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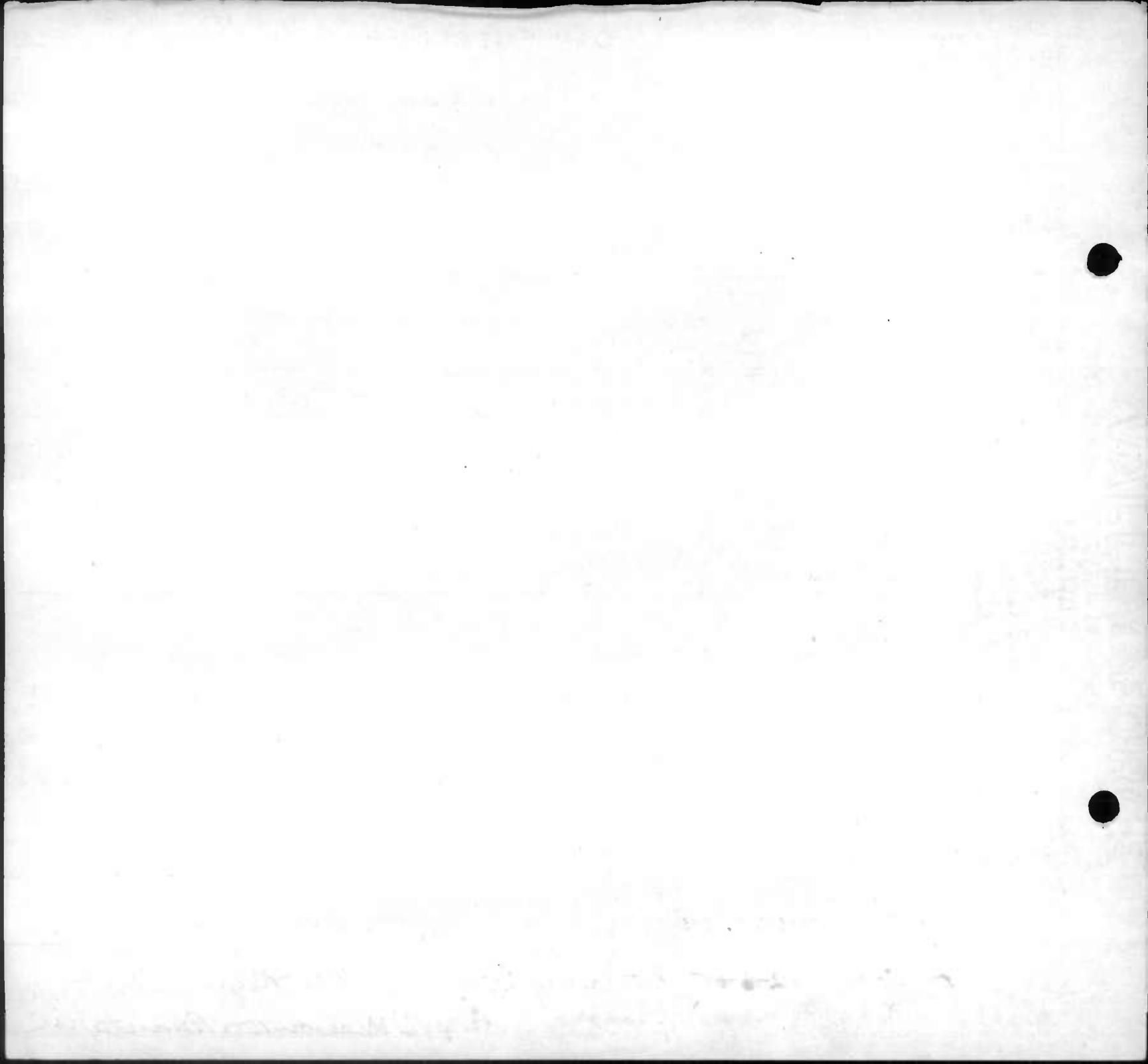
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-230

BALTIMORE CITY HEALTH DEPARTMENT				65 12735	
CERTIFICATE OF DEATH				Registered No. 65 12735	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Betha, Andrew, Jr.		12/13/65		2:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
91 Montebello State Hospital		Maryland Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		D. STREET ADDRESS (If rural, give location)			
		1613 N. Broadway			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Male	negro	married	6/6/1908	57	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Ship Fitter				South Carolina	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Andrew Beetha, Sr.		Zliza Mason		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		217-09-5345		Hospital Records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
163X I		Squamous Cell Carcinoma of the lungs		6 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
O					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/11/65 to 12/13/65, that (I) (we) last saw the deceased alive on 12/13/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Daniel G. Lai				12/13/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Daniel G. Lai		2201 Argonne Drive, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12-16-65		Mt Calvary Court	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 14 1965		R. E. [Signature]		[Signature] 1100 Broadway Ave	



65 12736

BALTIMORE CITY HEALTH DEPARTMENT

65 12736

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HENRY GOODWIN

2. DATE AND HOUR PRONOUNCED DEAD

12/13/65 10:00 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1031 N. Gay St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Dec 23-1895

9. AGE (In years
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Labor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Georgetown S. Carolina

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Elijah Goodwin

14. MOTHER'S MAIDEN NAME

Oussine Henderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

16. SOCIAL
SECURITY NO.

251-07-6347

17. INFORMANT

Beatrice Goodwin

ADDRESS

Same

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)

Carcinoma of epiglottitis

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/14/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 14 1965

Robert E. [unclear]

Chas. A. Wilson 1000 [unclear]

Journal

1892-1893

1892-1893

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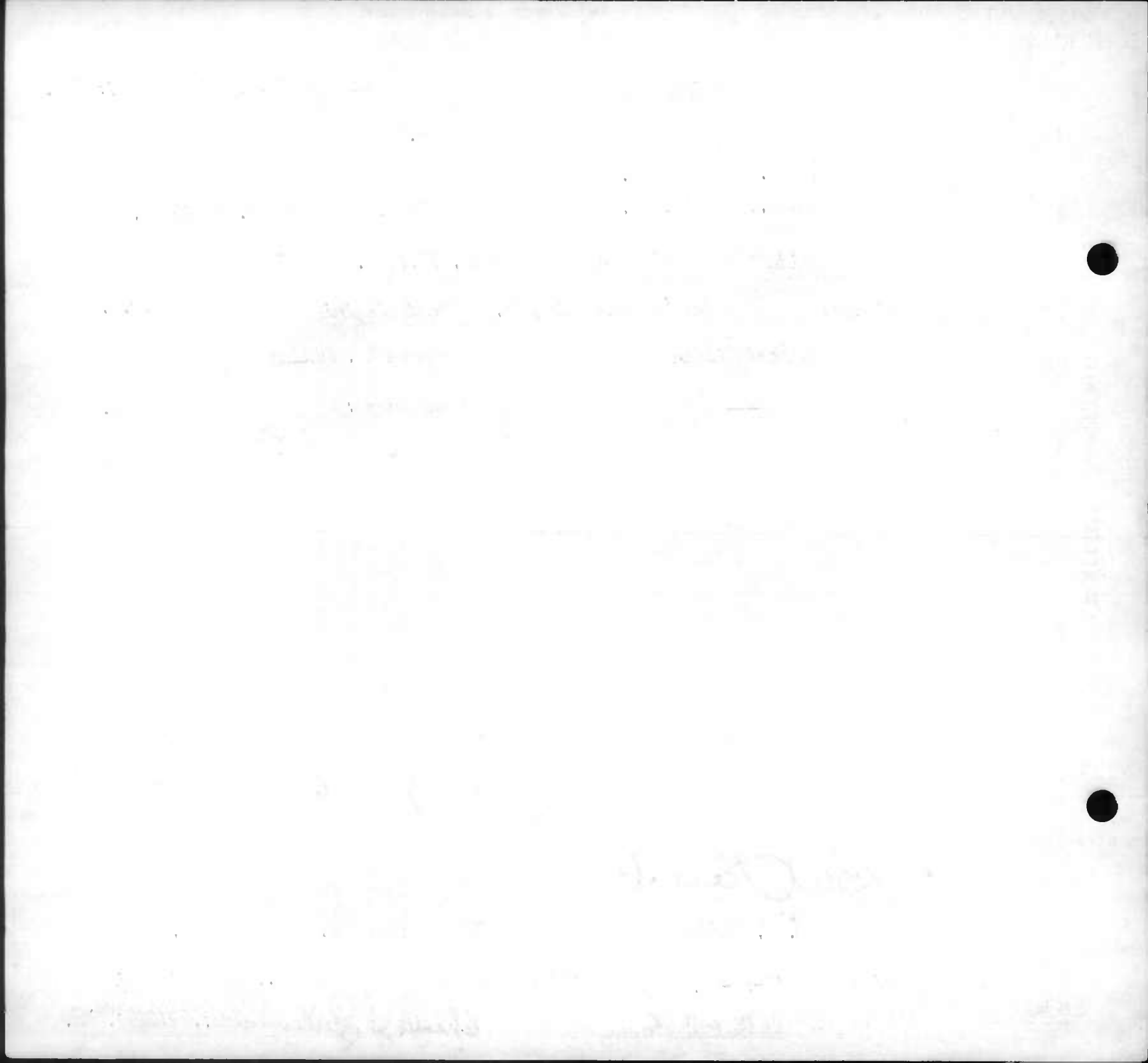
1892-1893

1892-1893

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

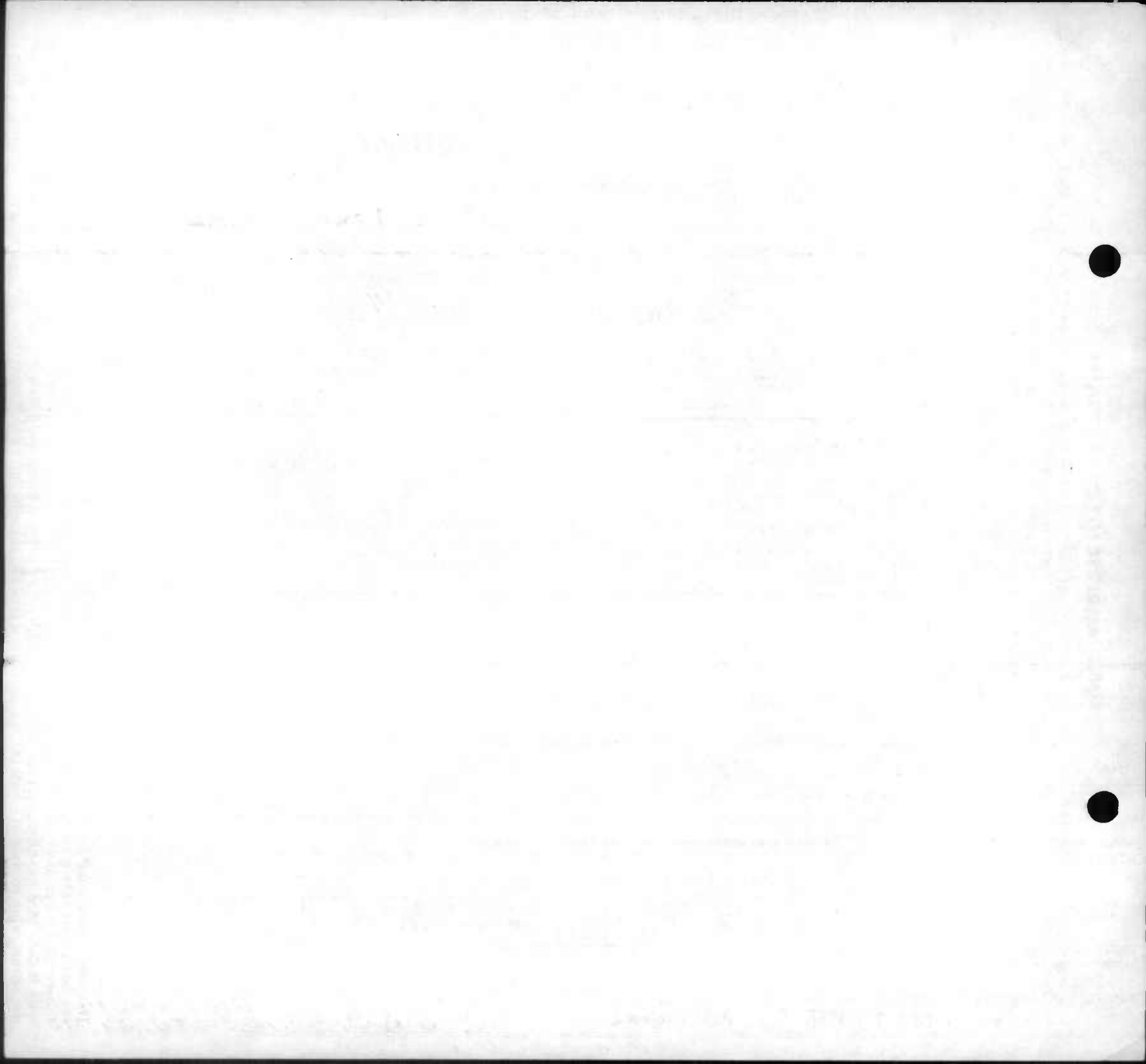
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12737	
BIRTH NO. 65 12737		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH December 9, 1965 11:25 P. M.			
1. NAME OF DECEASED (Type or Print) Barberine Bell		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md. B. COUNTY 76-05			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 425 S. Angelsea St. Balto., 21224, Md.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 425 S. Angelsea St. # 21224.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH Oct. 12, 1915.	9. AGE (In years last birthday) 50	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10B. KIND OF BUSINESS OR INDUSTRY Berg's Farm Dairy Co.		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME Tolbert Miller		14. MOTHER'S MAIDEN NAME Emmer R. Miller			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Andrew Booz :	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 153.91 Carcinoma of Bowel		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
<p style="text-align: center;">II</p> <p>18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 1965 to Nov. 1965 , that (I) (we) last saw the deceased alive on Nov. 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B. W. Sollod				23B. DATE SIGNED 12-10-65	
23C. PHYSICIAN'S NAME (Type) B. W. Sollod				23D. ADDRESS 2900 Dunran Rd. Dundalk, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-13-65		24C. NAME OF CEMETERY or CREMATORY Stacey Miller Cemetery	
24D. LOCATION (City, town, or county) (State) Boone Co., West Virginia		25A. DATE REC'D BY HEALTH DEPT. DEC 15 1965			
25B. NAME OF REGISTRAR Robert P. Fagan		25C. FUNERAL DIRECTOR Charles J. Zeller			
25D. ADDRESS 6224 Eastern Ave. Balto., 21224, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

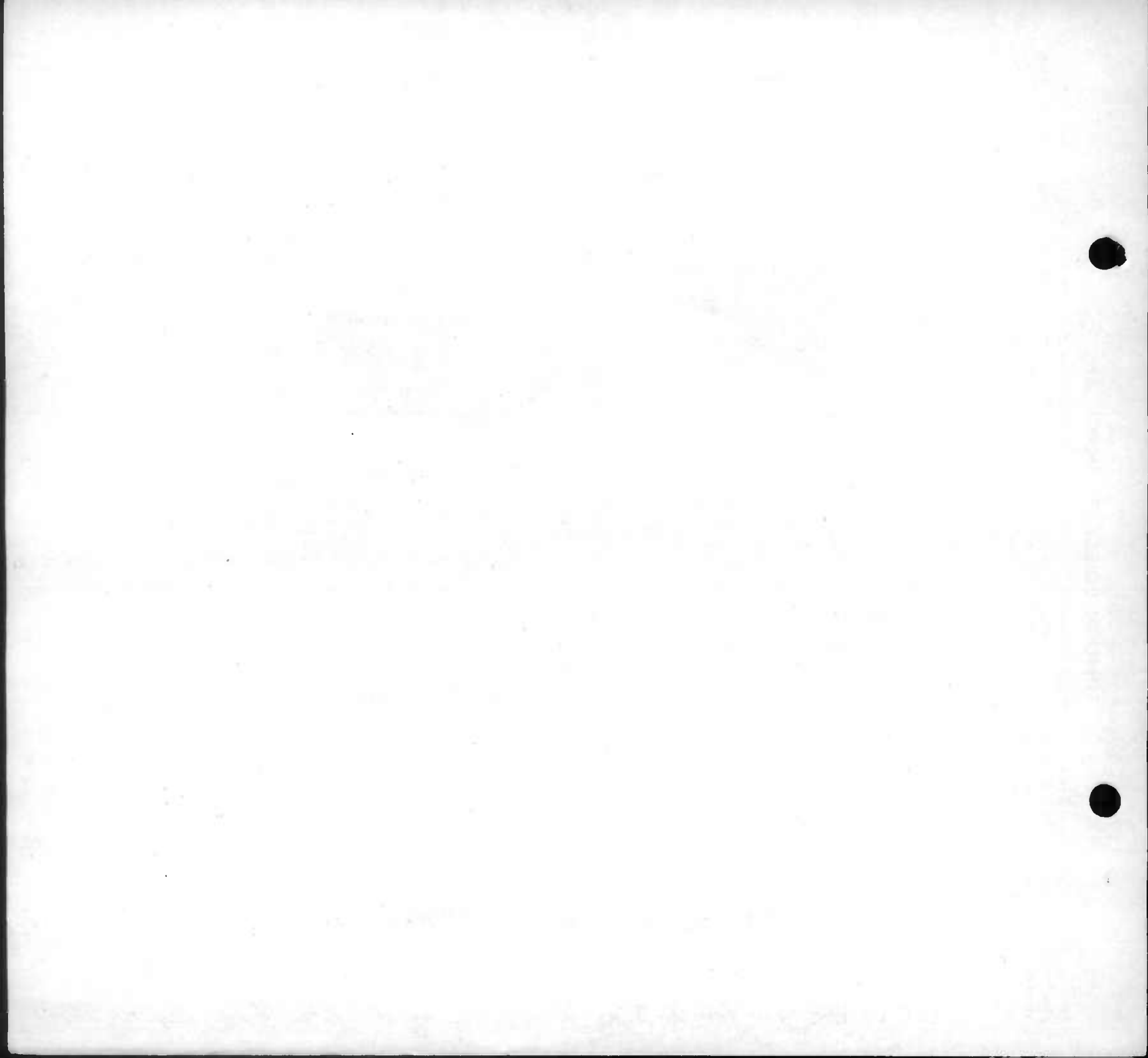
BIRTH NO. 65-30908 65 12738				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 12738	
1. NAME OF DECEASED (Type or Print) Baby Girl Gamber				2. DATE AND HOUR OF DEATH 12-10-65 10¹⁰ P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) ESSEX - RURAL D. STREET ADDRESS (If rural, give location) 1002 FOXWOOD LANE #21			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 12-9-65	9. AGE (In years last birthday) —	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		
11. BIRTHPLACE (State or foreign country) BALTIMORE MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME EARL E. GAMBER				14. MOTHER'S MAIDEN NAME MARGARET S. SULLIVAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS EARL E. GAMBER SAME			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cerebral hemorrhage.				INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral anoxia.				20. abruptio placentae.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12-9-65 to 12-10-65 , that (I) (we) last saw the deceased alive on 12-10-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Perry S. Shelton M.D.				23B. DATE SIGNED 12-11-65		23C. PHYSICIAN'S NAME (Type) Perry S. Shelton M.D.	
23D. ADDRESS Mercy Hospital		24. LOCATION (City, town, or county) (State) BALTIMORE CO., MD.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-13-65		24C. NAME OF CEMETERY or CREMATORY GARDENS OF FAITH		24D. ADDRESS 9015 CONKLING ST. BALTO., MD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1965		25B. NAME OF REGISTRAR Charles J. Guler		25C. FUNERAL DIRECTOR Charles J. Guler			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

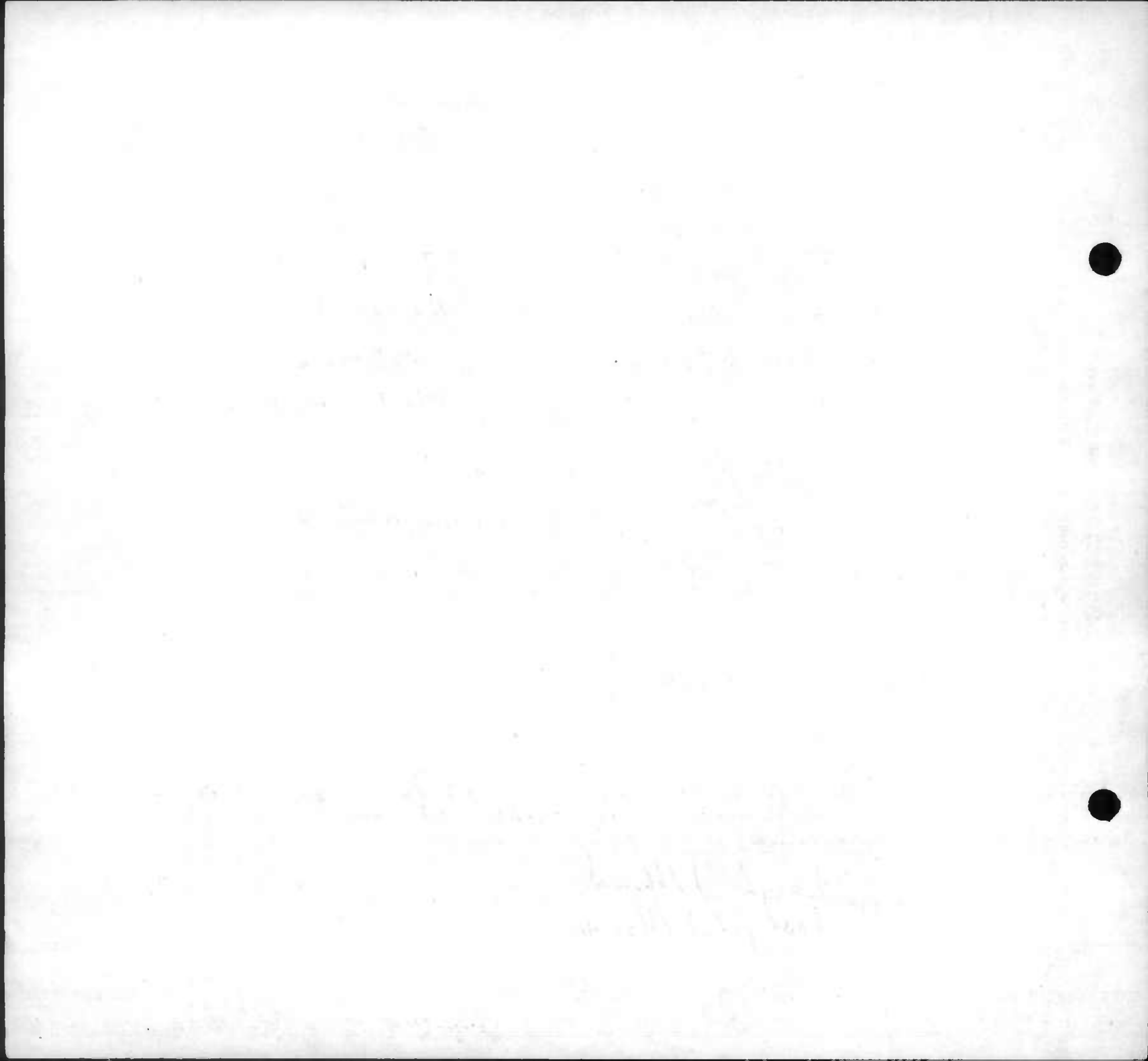
BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 65 12739					CERTIFICATE OF DEATH			Registered No. 65 12739		
M.E. CASE NO.					2. DATE AND HOUR OF DEATH					
1. NAME OF DECEASED (Type or Print) ALBERT JUSTUS WIRSCHNITZER					12-8-65 9:50 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND MUELLER					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-02					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 36 FRANKLIN SQUARE HOSPITAL					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE					
D. STREET ADDRESS (If rural, give location) 4501 HAMPVETT AVE.										
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9-23-07	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) C.P.A.			10B. KIND OF BUSINESS OR INDUSTRY 31		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME CHARLES E WIRSCHNITZER					14. MOTHER'S MAIDEN NAME MINNIE MUELLER					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?			16. SOCIAL SECURITY NO. 216-05-2330		17. INFORMANT MEDICAL RECORDS			ADDRESS		
18. 199.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinoma metastasis, primary DUE TO (B) undetermined (C) Pulmonary atelectasis and edema					INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from 10-31 19 65 to 12-8 19 65, that (I) (we) last saw the deceased alive on 12-8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE J. R. de Boya					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 12-8-65		
23C. PHYSICIAN'S NAME (Type) JACINTO V. DE BORJA					23D. ADDRESS FRANKLIN SQUARE HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-11-65		24C. NAME OF CEMETERY or CREMATORY PARKWOOD CEMETERY		24D. LOCATION (City, town, or county) (State) BALTO. Co., MD.				
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1965			25B. NAME OF REGISTRAR R. E. Johnson			25C. FUNERAL DIRECTOR Chas. R. Funeral Home			ADDRESS BALTO., MD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
65 12740					Certificate of Death					Registered No. 65 12740				
BIRTH NO.					1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
					August Stenzy					Dec. 12, 1965 1140 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION					A. STATE					B. COUNTY				
UNIVERSITY HOSPITAL					SPRING GROVE STAD Hosp									
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)					BALTIMORE 6300				
					D. STREET ADDRESS (If rural, give location)									
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
MALE		WHITE		WIDOWER		2-22-71		94						
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?		
Retired				MACHINE SHOP				AUSTRIA				USA		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME								
Andrew Stenzy						UNKNOWN								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS				
NO						STATE Hospital				SPRING GROVE				
18. 05341						CAUSE OF DEATH						INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH						(A) DUE TO						SEPTICEMIA - RENAL shutdown		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)						(B) DUE TO						Urinary retention & instrumentation		
ANTECEDENT CAUSES						(C)								
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.														
II														
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
12/11		Retention				NO								
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.)		(Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?								
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>										
22. I certify that (I) (this hospital) attended the deceased from 12-12 1965 to 12-12 1965, that (I) (we) last saw the deceased alive on 1130 12/12 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE						23B. DATE SIGNED								
Joseph J. Mowad						12/12								
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS										
Joseph J. Mowad														
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)								
BURIAL		12/15/65		ST. STANISLAUS CEM		BALTIMORE MD								
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS								
DEC 15 1965				Robert E. F...		VALERIE FUNERAL HOME-DUNDALK MD								



39-81-81
JJ 5-351

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

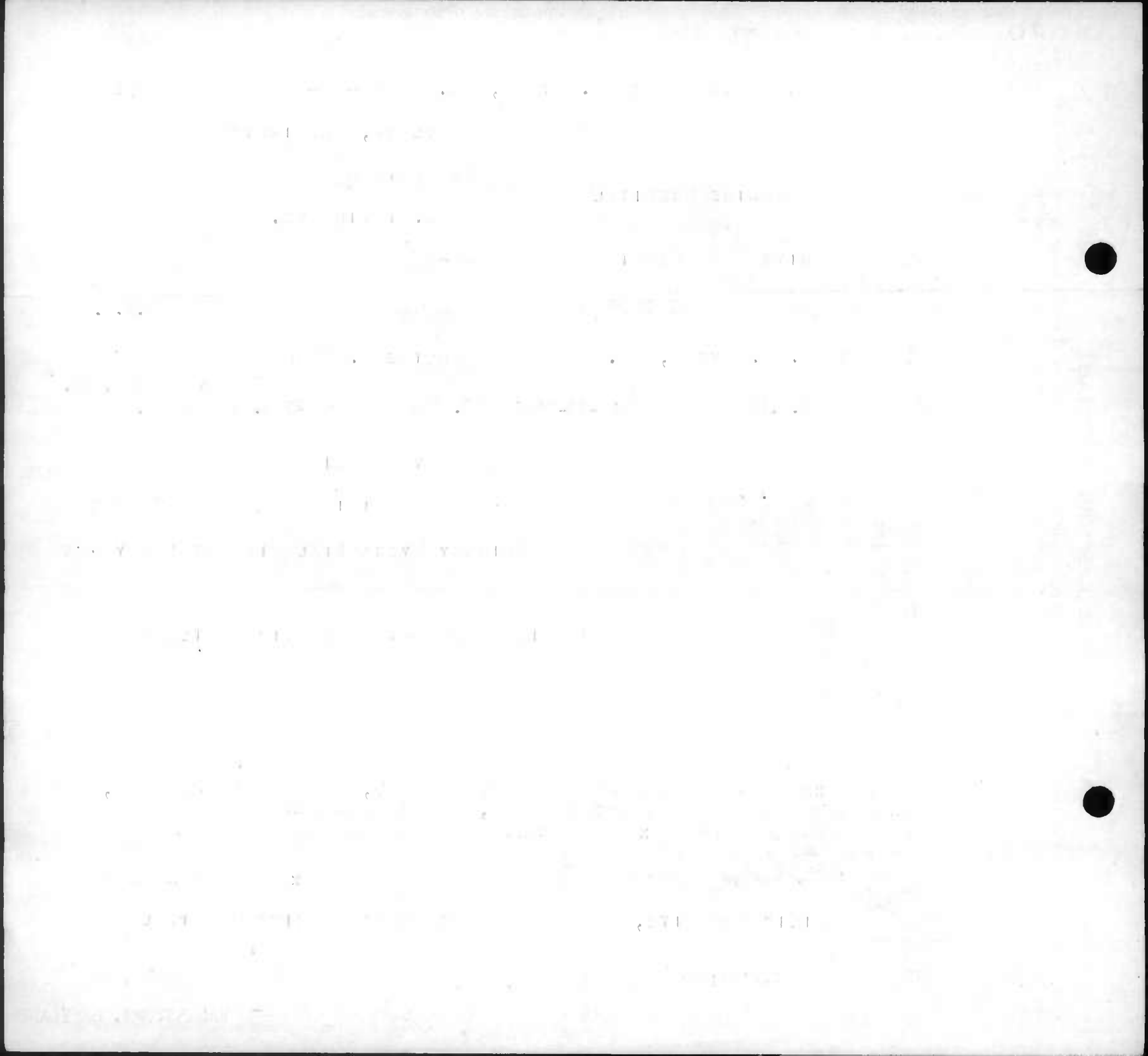
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12741	
BIRTH NO. 65 12741		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) ADOLPH STUMP		12-11-65 5:30 PM.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4940 EASTERN AVENUE #			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 3-19-1907	9. AGE (In years last birthday) 58	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BETHLEHEM STEEL		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME WM. STUMP		14. MOTHER'S MAIDEN NAME LOUISE STORATH		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-01-2105		17. INFORMANT ADDRESS RECORDS: BCH 4940 EASTERN AVENUE #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 322.21 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) PNEUMONIA (B) Hepatic coma failure (C) Alcoholism		INTERVAL BETWEEN ONSET AND DEATH 2 wks 1 m 20 m	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Duodenal ulcer		10 wks?	
19A. DATE OF OPERATION 3		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/30 1964 to 12/11 1965, that (I) (we) last saw the deceased alive on 12/11 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G. GEY		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/11/65	
23C. PHYSICIAN'S NAME (Type) G. GEY		23D. ADDRESS M.D. 4940 EASTERN AVENUE #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/15/65		24C. NAME OF CEMETERY or CREMATORY Oak Lawn	
24D. LOCATION (City, town, or county) (State) Balto. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 15 1965			
25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR ADDRESS A. W. [unclear] 3218 HUDSON ST.			

Received of
The Treasurer
of the
Board of Directors

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12742	
BIRTH NO. 65 12742		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CLARENCE HORACE R. MYERS, JR.		2. DATE AND HOUR OF DEATH 12-12-65 9:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND, WASHINGTON B. COUNTY HAGERSTOWN C. CITY OR TOWN (If outside city limits, write RURAL and give township) HAGERSTOWN D. STREET ADDRESS (If rural, give location) 27 E. IRVIN AVE.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8-5-18	9. AGE (In years last birthday) 47	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROGRAM MANAGER		10B. KIND OF BUSINESS OR INDUSTRY AIRCRAFT		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CLARENCE H. R. MYERS, SR.		14. MOTHER'S MAIDEN NAME PAULINE A. CONNER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.II		16. SOCIAL SECURITY NO. 214-09-7585		17. INFORMANT MRS. HAZEL MYERS ADDRESS HAGERSTOWN, MD.	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CHRONIC RECURRENT CONGESTIVE FAILURE		CAUSE OF DEATH (A) PULMONARY EMBOLI DUE TO THROMBOPHLEBITIS (B) PRIMARY MYOCARDIAL DISEASE DUE TO 10 YEARS (C)		INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 1 WEEK	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that XIX (this hospital) attended the deceased from NOVEMBER 21, 1965 to DECEMBER 12, 1965 , that (I) (we) last saw the deceased alive on DECEMBER 12, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Philip Horowitz</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-12-65	
23C. PHYSICIAN'S NAME (Type) PHILIP HOROWITZ,		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/15/1965		24C. NAME OF CEMETERY or CREMATORY REST HAVEN CEMETERY	
24D. LOCATION (City, town, or county) (State) HAGERSTOWN MARYLAND		25A. DATE REC'D BY HEALTH DEPT. DEC 15 1965			
25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Robert E. Johnson</i> ADDRESS HAGERSTOWN, MARYLAND			

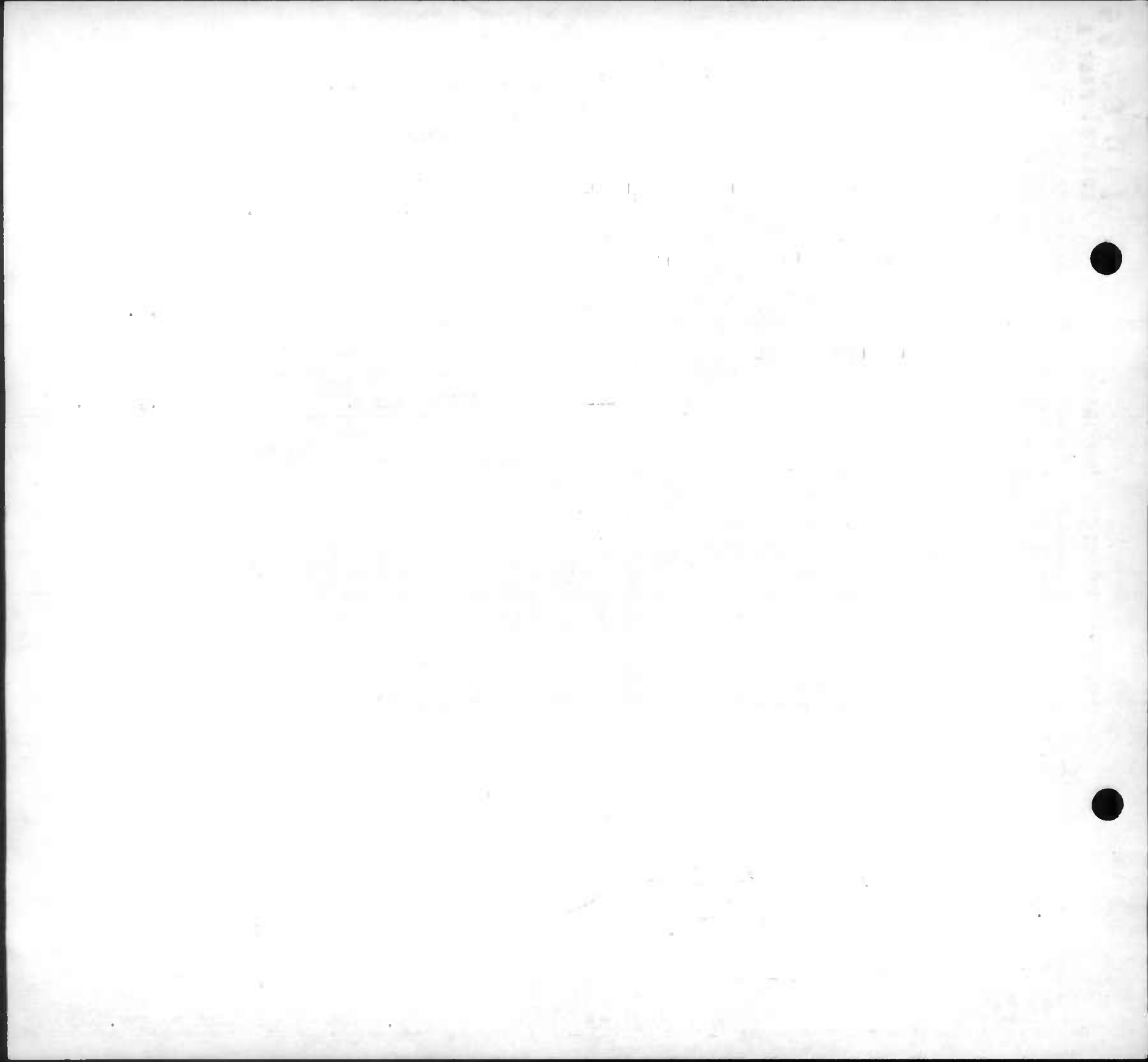


110 80 65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12743	
BIRTH NO. 65 12743		CERTIFICATE OF DEATH			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) MARY LORBER		2. DATE AND HOUR OF DEATH 12.8.65		9:15 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 525 N. DECKER AVE.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 10-4-88	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
13. FATHER'S NAME WILLIAM BLOSL		14. MOTHER'S MAIDEN NAME BARBARA SHANNA		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT ADDRESS William Lorber - 3913 Second St., Balto. 25	
18. 199.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute renal and hepatic failure INTERVAL BETWEEN ONSET AND DEATH 1 DAY		(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO METASTATIC CA.			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12.6 19 65 to 12.8 19 65 , that (I) (we) last saw the deceased alive on 12.8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Herman K. Gold				23B. DATE SIGNED 128 65	
23C. PHYSICIAN'S NAME (Type) Herman K. Gold		23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-13-1965		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1965		25B. NAME OF REGISTRAR George J. Gonde		25C. FUNERAL DIRECTOR ADDRESS 4001 Ritchie Hwy. (25)	



CERTIFICATE OF DEATH

Registered No.

65 12744

BIRTH NO.

65 12744

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Madeline Bayha

2. DATE AND HOUR OF DEATH

December 12, 1965 1:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital) or institution, give street
address or location)

Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Baltimore 21222

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

8219 Long Point Road

5300

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

10/6/92

9. AGE (In years
last birthday)

73 yr

10. Under 1 Yr.
Months Days11. Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSE WIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

OHIO

12. CITIZEN OF
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

ANNA SELBY

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

NONE

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue

21224

18. 467.21

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

12/12/65

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Gargantuan Bowel

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
WorkNot While
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ~~12/5~~ 12/7 1965 to 12/13/65 19
that (I) (we) last saw the deceased alive on 12/12 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

R. Stuart Weeks

M.D.

Attending
Phys.Med.
DirectorStoll
Phys.

23B. DATE SIGNED 12/12/65

23C. PHYSICIAN'S
NAME (Type)

R. Stuart Weeks

23D. ADDRESS

M.D.

4940 Eastern Avenue, Baltimore,
Maryland24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

12/16/65

24C. NAME OF CEMETERY or CREMATORY

ATONEMENT

24D. LOCATION
(City, town, or county)

CROOKS VILLE, OHIO

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 15 1965

25B. NAME OF REGISTRAR

Reg. E. J. Taylor

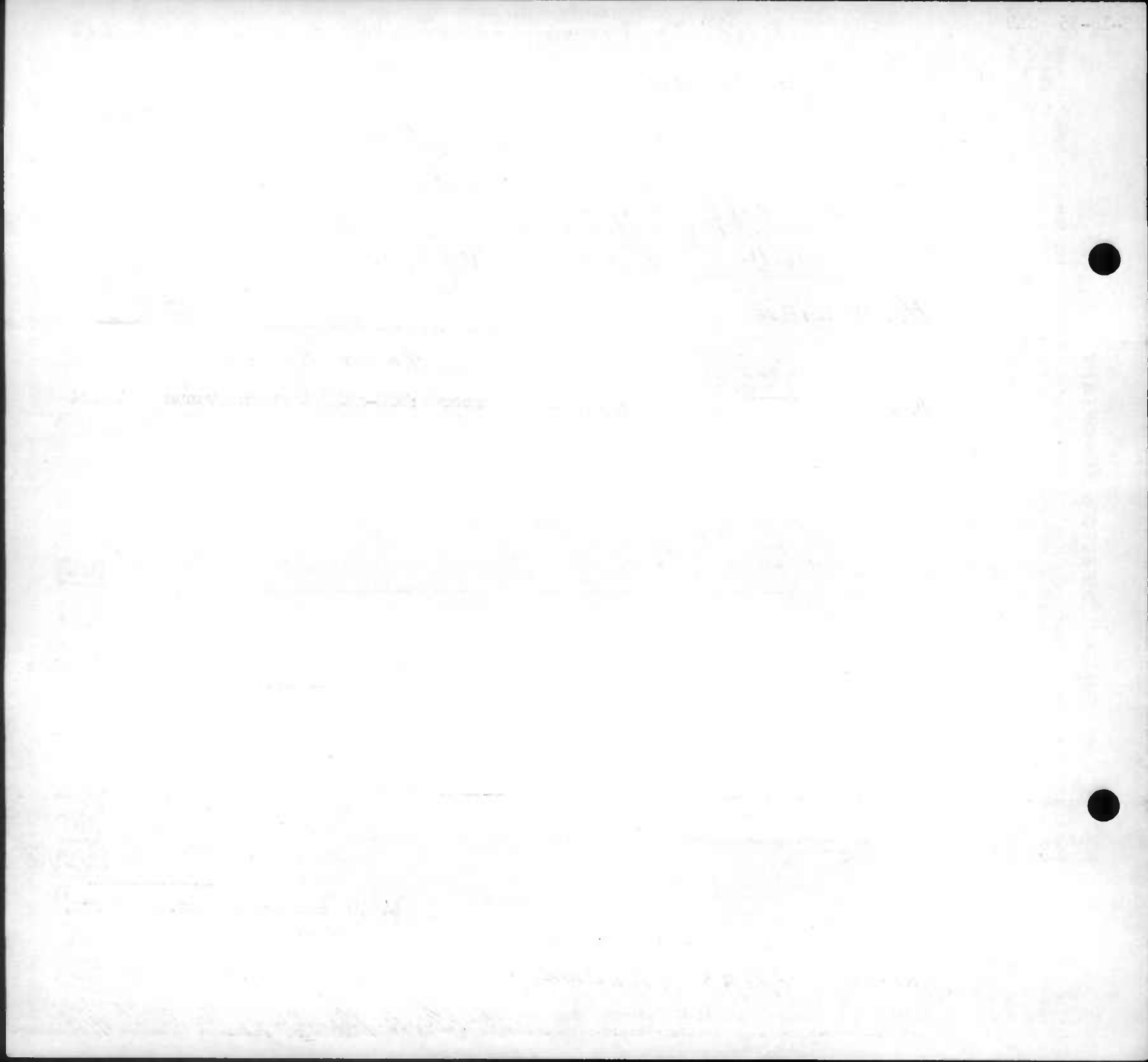
25C. FUNERAL DIRECTOR

Reg. B. B. Bradley, Woodlawn, Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

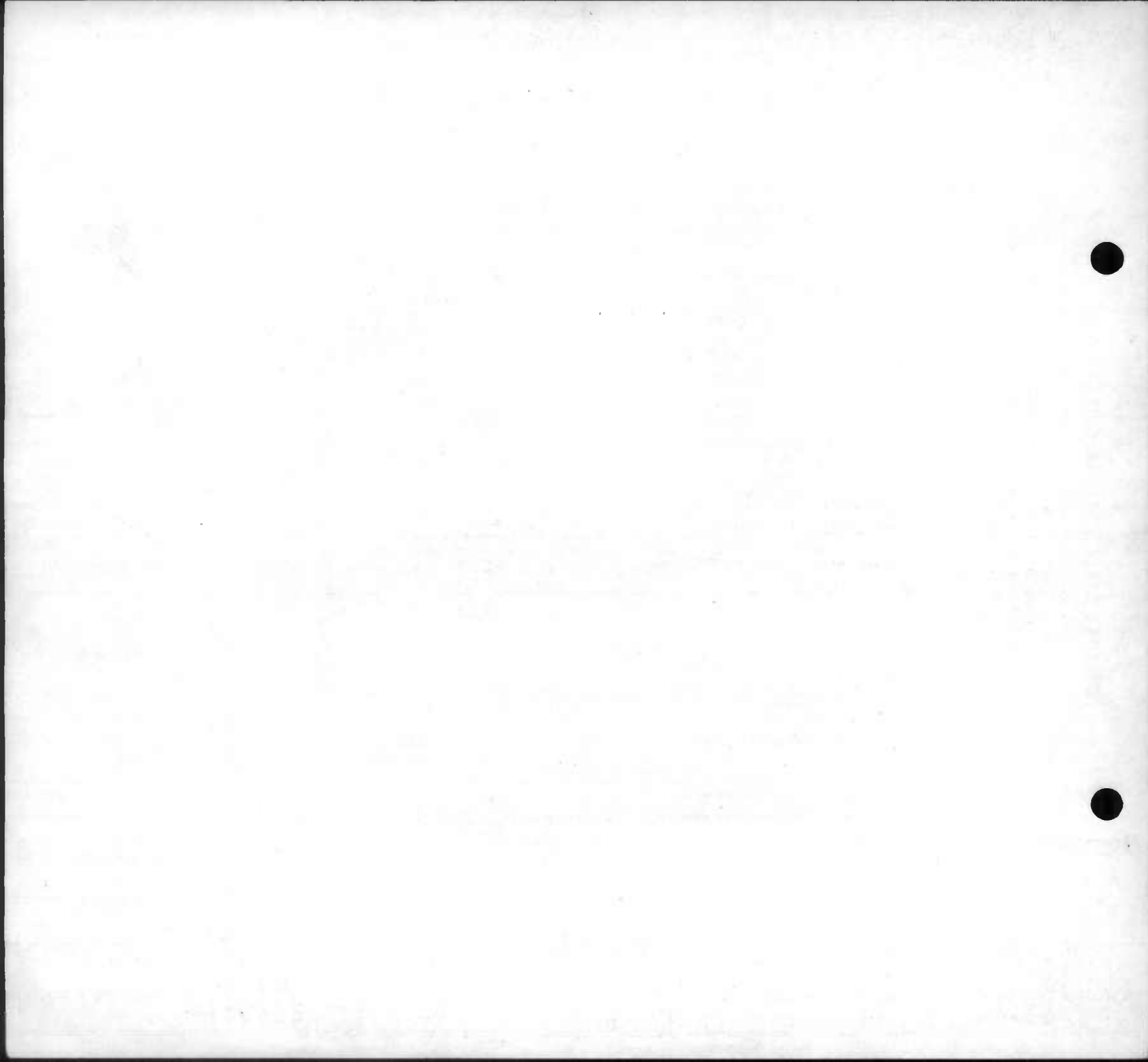
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12745		CERTIFICATE OF DEATH		Registered No. 65 12745	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HEROLD, Joseph F. Sr.		2. DATE AND HOUR OF DEATH 12-12-65 6:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 26-02		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME & HOSPITAL		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 5200 Nuth AVE.	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH Nov. 9, 1905	9. AGE (In years last birthday) 60
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yard Master		10B. KIND OF BUSINESS OR INDUSTRY Pa. R. R.		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
13. FATHER'S NAME FRANK HEROLD		14. MOTHER'S MAIDEN NAME Havlik Sophie HAULIK		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Louise Florence Thomas Herold, wife, above	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) VENTRICULAR FIBRILLATION AND SHOCK		CAUSE OF DEATH AND SHOCK		INTERVAL BETWEEN ONSET AND DEATH MINUTES	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) EXTENSIVE MYOCARDIAL INFARCTION		HOURS	
		(C) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		HOURS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-12-1965 to 12-12-1965 , that (I) (we) last saw the deceased alive on 12-12-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ephraim B. Barzaga M.D.				23B. DATE SIGNED 12-12-65	
23C. PHYSICIAN'S NAME (Type) EPHRAIM B. BARZAGA M.D.		23D. ADDRESS CHURCH HOME & HOSP. BALTO. 31, MD			
24A. BURIAL/CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/16/65		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1965		25B. NAME OF REGISTRAR DEC 15 1965		25C. FUNERAL DIRECTOR Schimmunek Funeral Home, Inc.	
				ADDRESS 3331 Treble Lane	



FOR APPROVAL BY MEDICAL EXAMINER
PER DR. SPITZ
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner of this assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12746		CITY OF BALTIMORE CERTIFICATE OF DEATH		Registered No. 65 12746	
1. NAME OF DECEASED (Type or Print) <i>Addick, Margaret G.</i>			2. DATE AND HOUR OF DEATH <i>12-11-65 1:05 P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>23 Johns Hopkins Hospital</i>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Balto Md.</i> B. COUNTY <i>7-03</i>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>23 Johns Hopkins Hospital</i>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto Md.</i>		
			D. STREET ADDRESS (If rural, give location) <i>907 North Duncan Street 21205</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>3/31/96</i>	9. AGE (In years last birthday) <i>69</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Subway Worker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Helwig & Leach</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Kanderson, Edward</i>			
14. MOTHER'S MAIDEN NAME <i>Cunningham, Katherine</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>—</i>			
16. SOCIAL SECURITY NO. <i>22-1226488</i>		17. INFORMANT ADDRESS <i>Louise M. Jackson, above, daughter</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>410X I</i> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>2. 1965</i>			CAUSE OF DEATH (A) <i>Acute Renal Failure</i> DUE TO (B) <i>Acute Renal Vessel Thrombosis</i> DUE TO (C) <i>Rheumatic Heart Disease (mitral STENOSIS)</i>		
INTERVAL BETWEEN ONSET AND DEATH			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes mellitus</i>		
19A. DATE OF OPERATION <i>12/7/65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>ILIOFEMORAL EMBOLI</i>		20A. AUTOPSY? (Yes or No) <i>YES.</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>12/11/65</i>		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/7/65</i> to <i>12/11/65</i> 19 that (I) <u>we</u> last saw the deceased alive on <i>12/11/65</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Walter D. Gundel</i>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> <i>HOUSE</i> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>12/11/65</i>
23C. PHYSICIAN'S NAME (Type) <i>WALTER D. GUNDEL</i>			23D. ADDRESS <i>Johns Hopkins Hospital - Dept. of Surgery</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/14/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Gardens of Faith Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 15 1965</i>			
25B. NAME OF REGISTRAR <i>W. A. P. Jones</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Schimunek Funeral Home, Inc. 2601-03-05 E. Madison Street 21205</i>			

16

1944-1945

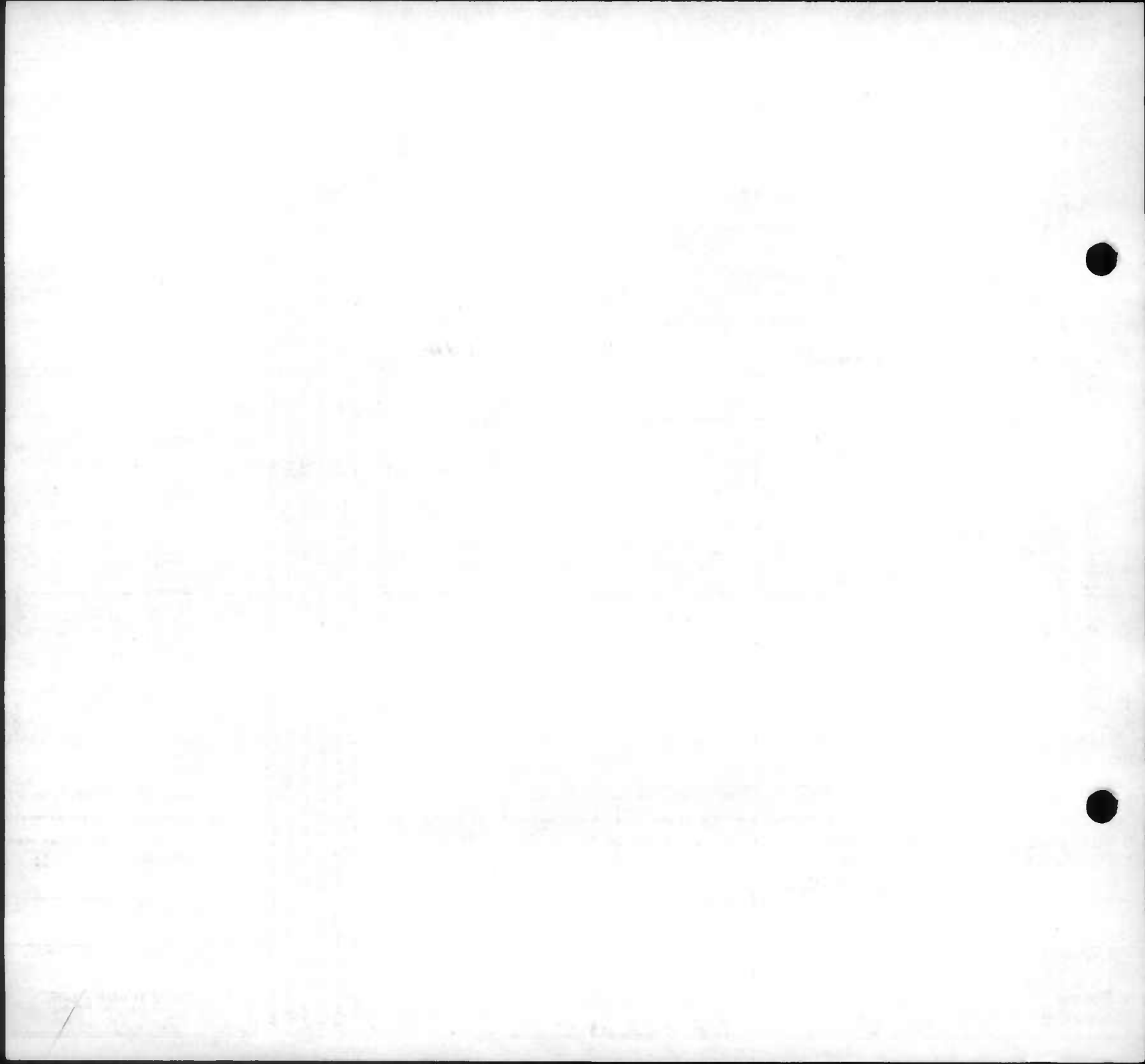
1944-1945

1944-1945

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12747		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12747	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) NATHAN BLUM		2. DATE AND HOUR OF DEATH DEC. 12, 1965 5 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPT.		A. STATE MARYLAND B. COUNTY 15-10 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3824 W. COLD SPRING LANE			
5. SEX MALE	6. RACE WHITE	7. MARRIED; NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8-16-1901	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY PAINT MFG. CO.		11. BIRTHPLACE (State or foreign country) BALTO. MD	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME BENJAMIN		14. MOTHER'S MAIDEN NAME IDA		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT GERTRUDE BLUM -		ADDRESS SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 420.1 I CAUSE OF DEATH (A) DUE TO coronary infarction (B) DUE TO AS EVD (C) _____ INTERVAL BETWEEN ONSET AND DEATH		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nutily medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1955 to 1965 that (I) (we) last saw the deceased alive on 12-12-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 805 Finselage Ave			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/13/1965		24C. NAME OF CEMETERY or CREMATORY MT. CARMEL	
24D. LOCATION (City, town, or county) (State) BALTO MD		25A. DATE REC'D BY HEALTH DEPT. DEC 15 1965			
25B. NAME OF REGISTRAR P.O. A.E. [Signature]		25C. FUNERAL DIRECTOR Sydney S. [Signature] & Son, Inc. 3319 OLYMPIA AVE			



FUNERAL DIRECTOR: IMPORTANT

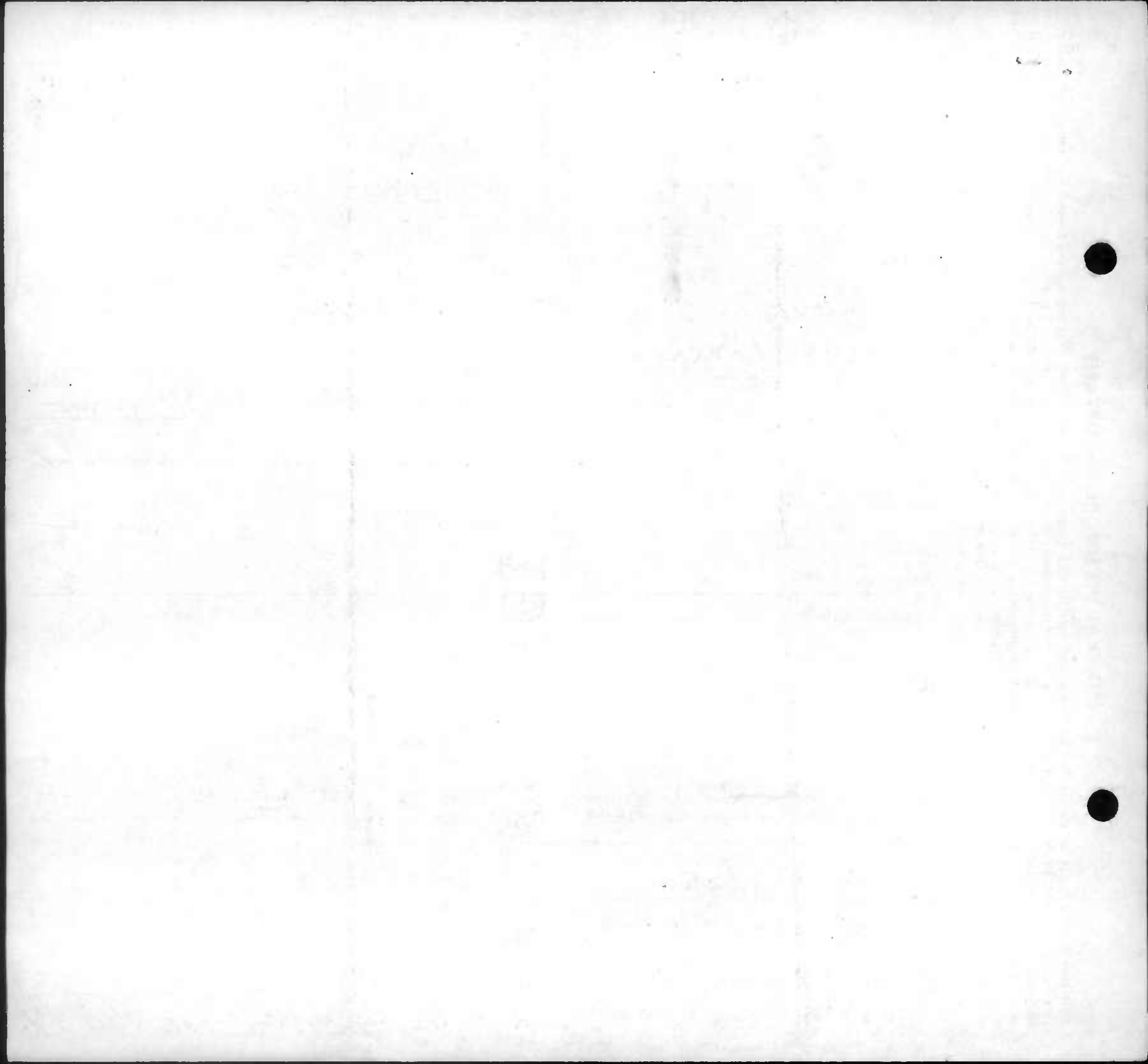
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death is shown: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Death was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		65 12748		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		65 12748	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH					
		JEANNETTE ORTIZ		12-11-65		6:22 p.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY			
35 Church Home & Hospital				Maryland		25-04			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
				Baltimore					
				D. STREET ADDRESS (If rural, give location)					
				3616 9th St. Brooklyn 5					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months: Days	11. UNDER 24 Hrs. Hours: Min.			
F	W	MARRIED	9-21-01	64					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife		At Home		Pennsylvania, Lock Haven		U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Samuel Shank				Rose Sach					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO		NO		Chant					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
260 X I				Arterio-sclerotic Cardio-vascular Disease		13 years			
ANTECEDENT CAUSES				(B) DUE TO		13 years			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)					
II				Pneumonia		7 days			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0				NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 12-4-1965 to 12-11-1965, that (I) (we) last saw the deceased alive on 12-11-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED			
D. A. E. Subong, Jr.						12-11-65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
D. A. E. Subong, Jr.				Church Home & Hosp					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
BURIAL		12/15/65		ARLINGTON NATIONAL CEMETERY		ARLINGTON, VIRGINIA			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
DEC 15 1965		R. L. E. Subong, Jr.		SOL LEVINSON & BROS. INC.		6010 REISTERSTOWN RD			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
65 12749 A. CERTIFICATE OF DEATH					Registered No. 65 12749				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) BARNEY BRICKEN					2. DATE AND HOUR OF DEATH Dec. 11, 65, about 1:30 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital					A. STATE Maryland B. COUNTY 15-38				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 3513 Fairview Ave.				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Dec 14, 1892	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10B. KIND OF BUSINESS OR INDUSTRY Mfg. Clothing		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME David Bricken			14. MOTHER'S MAIDEN NAME Hilda						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 102-07-7983		17. INFORMANT Sarah Bricken - 3513 Fairview Ave			ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 420.1 I					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
					(A) Acute Coronary Occlusion			about 1/4 hr	
					(B) Arteriosclerotic C.V.D.			years	
					(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from about 1950 to Dec 11, 1965 , that (I) was last saw the deceased alive on about Nov 30, 1965 and that in my ^{my} last ^{my} opinion death occurred on the date and hour and from the causes stated above. (I) was ^{did not} view the body after death.									
23A. SIGNATURE G. Highstein					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-11-65		
23C. PHYSICIAN'S NAME (Type) G. HIGHSTEIN M.D.					23D. ADDRESS 888 W. Lombard St.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec 12/65		24C. NAME OF CEMETERY or CREMATORY Har Zion		24D. LOCATION (City, town, or county) (State) Kredale, Md			
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1965		25B. NAME OF REGISTRAR Rebecca E. Johnson		25C. FUNERAL DIRECTOR Sol Leurgans - 6010 Reist Rd.		ADDRESS			



BIRTH NO.

65 12750

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 12750

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Sammy Lee ANDERSON

2. DATE AND HOUR PRONOUNCED DEAD

Dec. 12, 1965

1:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1532 Mount Royal Ave.

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

1/15/42

9. AGE (In years
last birthday)

23

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Mississippi

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Tommie Anderson

14. MOTHER'S MAIDEN NAME

Rachael Clinton

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

428-74-4083

17. INFORMANT

ADDRESS

Jos eph Anderson 2533 Emerson St.

18.

E 981 X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) GUNSHOT WOUND OF CHEST INVOLVING
AORTA AND LUNG.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Greenwillow and Pennsylvania Ave.

21D TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
Dec. 12 1965 1:10

21E. INJURY OCCURRED

A. WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

shot by friend

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Dec. 12, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/19/65

23C. NAME of CEMETERY or CREMATORY

Belzoni

23D. LOCATION

(City, town, or county)

(State)

Belzoni, Mississippi

24A. DATE REC'D BY HEALTH DEPT.

DEC 15 1965

24B. NAME OF REGISTRAR

Robert E. Spitz

24C. FUNERAL DIRECTOR

Charles A. Rice 661 W. Barre St.

ADDRESS

WALTER HOLROYD

PROPOSAL



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 12751	
BIRTH NO. 65 12751		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Rosie Roane		2. DATE AND HOUR OF DEATH 12/13/65 305 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE PENNSYLVANIA B. COUNTY V-35 C. CITY OR TOWN (If outside city limits, write RURAL and give township) PHILADELPHIA D. STREET ADDRESS (If rural, give location) 225 W. DUVAL ST.			
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		(If not in hospital or institution, give street address or location)		5. SEX FEMALE		6. RACE NEGROID	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE		8. DATE OF BIRTH 1-3-19		9. AGE (In years last birthday) 46		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) King William Co, Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JAMES ROANE		14. MOTHER'S MAIDEN NAME MARY ANNIE LEE		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 230-07-0133	
17. INFORMANT Mrs Vivian Stone		ADDRESS 2125 N. 22nd Phila. PA.		18. 5-92X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Gastrointestinal hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 6 hrs.	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) UREMIA		(B) Chronic Glomerulonephritis		1 1/2 mos.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Bacterial Frontal ethmoiditis		2 mos.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that at (this hospital) attended the deceased from 12/13 19 65 to 12/13 19 65 , that at (we) last saw the deceased alive on 12/13 19 65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.							
23A. SIGNATURE W.H. Spencer III				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/13/65	
23C. PHYSICIAN'S NAME (Type) W.H. SPENCER III				23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/19/65		24C. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery		24D. LOCATION (City, town, or county) (State) King William Co, Va.	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Joseph A. ...		ADDRESS 2222 N. ... Baltimore, Md.	

43-56-01

SAB

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 12752

BIRTH NO.

65 12752

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Fannie B. Jones

2. DATE AND HOUR OF DEATH

12-12-1965

12.20 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1221 North Decker Avenue 21224

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

7-18-1899

9. AGE (in years
last birthday)

66

10. Under 1 Yr. 11. Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Herny Seward

14. MOTHER'S MAIDEN NAME

Susie Seward

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18.

260 X
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) _____
DUE TO

September

hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B) _____
DUE TO

Urinary tract infection

1 month

(C) _____
DUE TO

Kimmelstiel Wilms disease

1 year

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Diabetes mellitus

10 yrs

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8-30 1965 to 12-12 1965,
that (I) (we) last saw the deceased alive on 12-12 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

John R. Burton

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

12-12-65

23C. PHYSICIAN'S
NAME (Type)

John R. Burton

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12/18/65

24C. NAME OF CEMETERY or CREMATORY

Mt Calvary Cemetery

24D. LOCATION

(City, town, or county)

Ann Arundel Cty., Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 15 1965

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Wm O March 928 E. North Ave.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1860

1861

1862

1863

1864

1865

1866

1867

1868

1869

The body of Sylvester Williams was released on approval by Dr. Linthicum to
Hopkins Hospital
The Johns
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12753		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 12753	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) SYLVESTER WILLIAMS		2. DATE AND HOUR OF DEATH 12-8-65		7:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 63-00 1220 NEIGHBORS AVE.			
5. SEX MALE	6. RACE NEGROID	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 11-30-17	9. AGE (In years last birthday) 48	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. BY M.D.		17. INFORMANT Mr. William Martin	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenie, etc. It means the disease, injury or complication which caused death.) Pneumonia		19. CAUSE OF DEATH Debilitation 2° to 50% 2°, 3°, 4° Burns		INTERVAL BETWEEN ONSET AND DEATH 6 days	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		21. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 4° Burns legs 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) address above 53-00 21C. WHERE DID INJURY OCCUR? 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 11-28-65 5:00 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> 21F. HOW DID INJURY OCCUR? fell asleep & lighted cigarette 22. I certify that (I) (his hospital) attended the deceased from 11-28 1965 to 12-8 1965, that (I) (we) lost saw the deceased alive on 7:35 P.M. 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE B. K. Gray 23C. PHYSICIAN'S NAME (Type) Barry K. Gray 23D. ADDRESS M.D. The Johns Hopkins Hospital 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 12/14/65 24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery 24D. LOCATION (City, town, or county) (State) Balto., Md. 25A. DATE REC'D BY HEALTH DEPT. DEC 15 1965 25B. NAME OF REGISTRAR J. E. March 25C. FUNERAL DIRECTOR 928 E. North Ave.			

J. T. H. H. H.

J. T. H. H. H.

RECEIVED
J. T. H. H. H.
J. T. H. H. H.

X

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

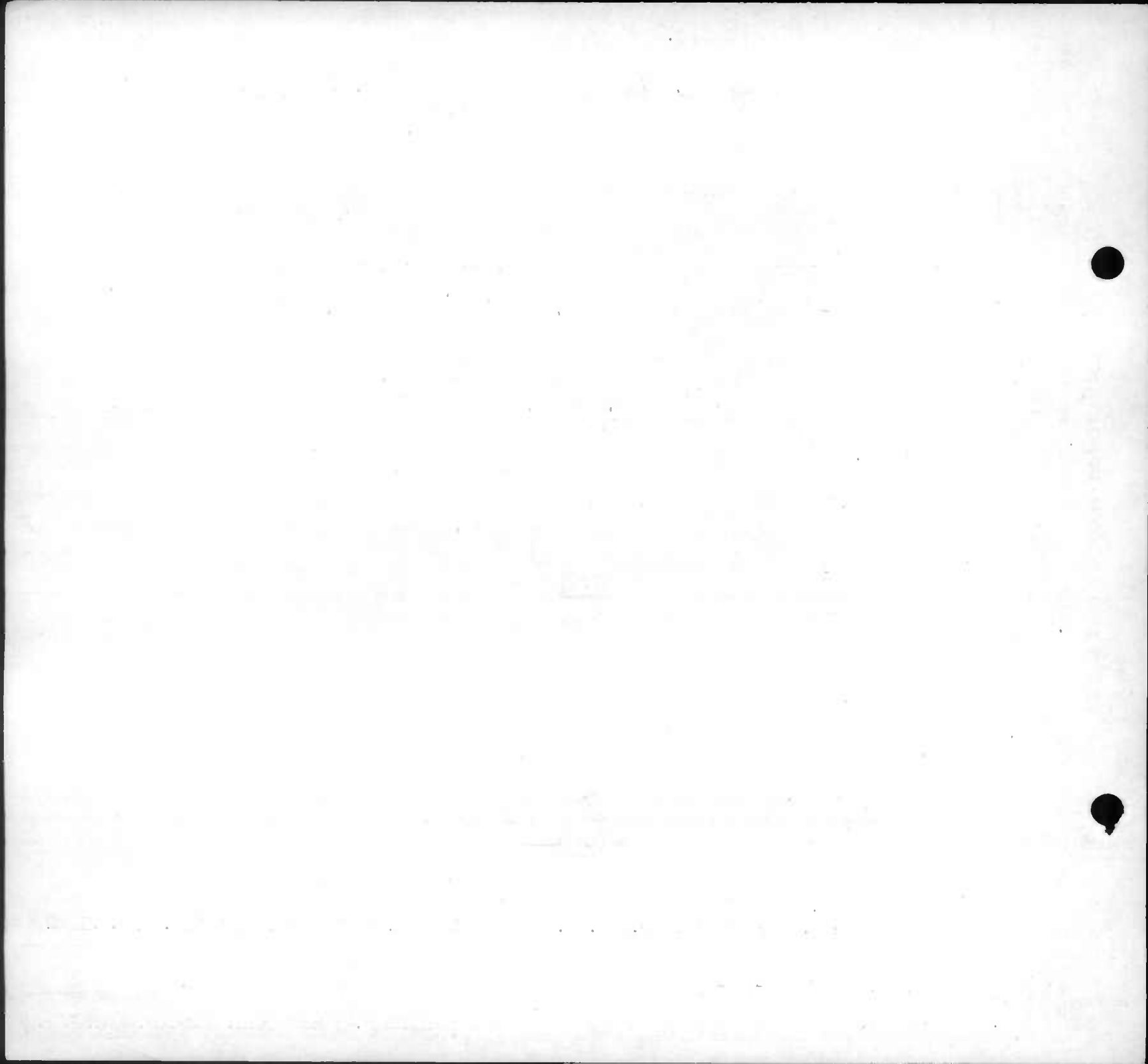
BIRTH NO. 65 12754		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 12754	
1. NAME OF DECEASED (Type or Print) PIGG, Curtis Lee, Sr.		2. DATE AND HOUR OF DEATH December 14, 1965 9:00 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTO.			
FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Reisterstown D. STREET ADDRESS (If rural, give location) 133 Westminster Road			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1/18/14	9. AGE (In years last birthday) 51	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shovel Operator
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shovel Operator		10B. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Pageland, S.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Arley Pigg			14. MOTHER'S MAIDEN NAME Mayme Watts		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 9/22/42-7/23/45		16. SOCIAL SECURITY NO. 249-14-7892		17. INFORMANT VA Hospital Records ADDRESS 3900 Loch Raven Blvd. Baltimore, Md., 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MASSIVE PULMONARY HEMORRHAGE		CAUSE OF DEATH (A) Massive Pulmonary Hemorrhage DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. TRACHEO-ESOPHAGEAL FISTULA		(B) Tracheo-esophageal fistula DUE TO		2 weeks	
		(C) Bronchogenic Carcinoma		8 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 9th 19 65 to December 14th 19 65 , that (I) (we) last saw the deceased alive on December 14th 19 65 and that in (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.					
23A. SIGNATURE <i>Richard F. Kieffer, Jr.</i>				23B. DATE SIGNED 12/14/65	
23C. PHYSICIAN'S NAME (Type) RICHARD F. KIEFFER, JR.		23D. ADDRESS Veterans Administration Hospital 3900 Loch Raven Boulevard, Balto., Md., 21218			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE Dec. 17/1965		24C. NAME OF CEMETERY or CREMATORY Evergreen Memorial Center, Finksburg, Md.	
24D. LOCATION (City, town, or county) (State) Finksburg, Md.					
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1965		25B. NAME OF REGISTRAR E. J. ...		25C. FUNERAL DIRECTOR Frank H. Newell, Pikesville, Md.	

John V. Kelly

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
65 12755					CERTIFICATE OF DEATH					Registered No. 65 12755				
BIRTH NO.					M.E. CASE NO.					1. NAME OF DECEASED (Type or Print)				
					Helen E. Haynes					2. DATE AND HOUR OF DEATH Dec. 14, 1965. 4:30 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 3215 Juneau Place										A. STATE Md. B. COUNTY 27-01				
C. CITY OR TOWN (If outside city limits, write RURAL and give township)										D. STREET ADDRESS (If rural, give location)				
Baltimore										3215 Juneau Place				
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. Under 1 Yr. Months: Days		11. Under 24 Hrs. Hours: Min.		
Female		White		Widow		June 7, 1893		72						
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country)				
President-Baltimore Rigging Co.					Baltimore, Md.					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
Edward McCauley					Elizabeth Dougherty					16. SOCIAL SECURITY NO. 215347375				
17. INFORMANT					ADDRESS					18. CAUSE OF DEATH				
Miss Elizabeth Haynes					same					19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
(A) Engine pectoris. onset approx. 1957					(B) coronary artery disease onset approx. 1957					(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										None				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 1/2 1958 to 12/4 1965, that (I) (we) last saw the deceased alive on 12/10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										23A. SIGNATURE George W. Murgatroyd, Jr., M.D.				
23B. DATE SIGNED 12/15/65					23C. PHYSICIAN'S NAME (Type) George W. Murgatroyd, Jr., M.D.					23D. ADDRESS 1127 St. Paul Street, Balto., Md. 21202				
24A. BURIAL CREMATION, REMOVAL (Specify) burial					24B. DATE 12-18-65					24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery				
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					25A. DATE REC'D BY HEALTH DEPT. DEC 15 1965					25B. NAME OF REGISTRAR Leonard J. Bruck Inc. Balto. Md. 21214				
25C. FUNERAL DIRECTOR					25D. ADDRESS					25E. DATE				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No.	
65 12756						65 12756	
1. NAME OF DECEASED (Type or Print) STERRETT, CHARLES H.				2. DATE AND HOUR OF DEATH 12/9/65 10:35 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTE			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE				C. CITY OR TOWN (If outside city limits, write RURAL and give township) GLYNDON			
				D. STREET ADDRESS (If rural, give location) 46 W. CHATSWORTH AVE.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 10/1/89	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ADVERTISING EXR.		10B. KIND OF BUSINESS OR INDUSTRY ADVERTISING		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME JOHN D. STERRETT				14. MOTHER'S MAIDEN NAME HARRIET GRAFF			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. WIN I U.S.N.		17. INFORMANT HELLER & BAUDOUX FUNERAL HOME		ADDRESS LEWISTON, PENN.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH INTRACRANIAL HEMORR				INTERVAL BETWEEN ONSET AND DEATH 48 hrs.			
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIOSCLEROSIS							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/9 19 65 to 12/10 19 65 , that (I) (we) last saw the deceased alive on 12/10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jerome Kimmel				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/10/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-12-65		24C. NAME OF CEMETERY or CREMATORY CHURCH HILL CEMETERY		24D. LOCATION (City, town, or county) (State) REEDSVILLE, PENNSYLVANIA	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1965		25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR Wm J. Brooks		ADDRESS 1050 YORK RD TOWSON MD 21204	

ANALYST: J. D. STREET
DATE: JUL 1 1954
TO: [illegible]
FROM: [illegible]

65 12757

BALTIMORE CITY HEALTH DEPARTMENT

65 12757

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) DORLY E HAYES				2. DATE AND HOUR PRONOUNCED DEAD December 9, 1965 10:25 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 3300 D. STREET ADDRESS (If rural, give location) 72 River Road			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 8, 17, 1946	9. AGE (In years last birthday) 19	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver			10B. KIND OF BUSINESS OR INDUSTRY CLOSURE COMPANY		11. BIRTHPLACE (State or foreign country) Tunnelton, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Clarence Hayes				14. MOTHER'S MAIDEN NAME Mona Duggar			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-48-2408		17. INFORMANT Alvie Hayes,		10E. Hickam Rd. ADDRESS Baltimore, Md. #20	
18. CAUSE OF DEATH Multiple Traumatic Injuries. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Holly Neck Rd., E. of Back River Neck Rd. 3300		
21D. TIME OF INJURY (APPROX.) 12 9 '65 P		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Driver of auto into fixed object.			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Petty, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Petty, M.D. M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/10/65							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 12, 13, 65		23C. NAME of CEMETERY or CREMATORY Kingwood		23D. LOCATION (City, town, or county) (State) Kingwood, W.Va.	
24A. DATE REC'D BY HEALTH DEPT. DEC 15 1965		24B. NAME OF REGISTRAR Wm. Cook-Brooks		24C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Md. #4 1050 York Rd. - Towson Md 21204			

WILLIAMSON

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 12758</u>	
BIRTH NO. <u>65 12758</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>EDWARD RAY</u>		2. DATE AND HOUR OF DEATH <u>DEC 10, 1965</u> <u>6 30</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u>		5. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>6300</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u>		6. STREET ADDRESS (If rural, give location) <u>329 SOUTH WIND ROAD</u>		7. AGE (In years last birthday) <u>79</u>	
8. SEX <u>M</u>	9. RACE <u>CAUCASIAN</u>	10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>M</u>	11. DATE OF BIRTH <u>1/3/86</u>	12. If Under 1 Yr. Months: Days: Hours: Min.	13. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GARDENER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>EDWARD RAY</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE FISHPAW</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>7</u>		17. INFORMANT <u>CHART</u>	
18. <u>491X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>BRONCHO PNEUMONIA</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(1) (this hospital)</u> attended the deceased from <u>NOV 20</u> 19 <u>65</u> to <u>DEC 10</u> 19 <u>65</u> , that <u>(1) (we)</u> last saw the deceased alive on <u>DEC 10</u> 19 <u>65</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(1) (We)</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Charles E. Boring</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>DEC 10, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>CHARLES E. BORING</u>		23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-13-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>PROSPECT HILL CEMETERY</u>	
24D. LOCATION (City, town, or county) (State) <u>TOWSON, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1965</u>			
25B. NAME OF REGISTRAR <u>P. E. J. J. J.</u>		25C. FUNERAL DIRECTOR <u>Wm. Cook Brooks</u>			
ADDRESS <u>TOWSON, M.D.</u>		ADDRESS <u>TOWSON, M.D.</u>			

~~CONFIDENTIAL~~

Handwritten signature

Handwritten initials

Handwritten number 24

CONFIDENTIAL - ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10/1/00 BY 1045/00

1045/00

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12759		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12759	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) MOORE, MELVINA NAOMI		
2. DATE AND HOUR OF DEATH 12/11/65 1:45 P.M.			3. PLACE OF DEATH IN BALTIMORE/MARYLAND		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSP		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, MARYLAND 21234	
D. STREET ADDRESS (If rural, give location) 2400 CUB HILL RD. 53-00		5. SEX F		6. RACE W	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)
8. DATE OF BIRTH 11/10/72		9. AGE (In years last birthday) 93		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) ALABAMA		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME RENO CLAYTON	
14. MOTHER'S MAIDEN NAME CLEMENTINE SAMPLEY		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK		16. SOCIAL SECURITY NO. UNK	
17. INFORMANT MISS IRENE MOORE S/A		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Pulmonary Edema		INTERVAL BETWEEN ONSET AND DEATH 48 h	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		20. A. DUE TO ASEVHD		B. DUE TO	
C. DUE TO		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
21A. DATE OF OPERATION 0		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (if) (this hospital) attended the deceased from 12/10/65 to 12/11/65, that (if) (we) lost saw the deceased alive on 12/11/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (if) (We) (did) (did not) view the body after death.		23A. SIGNATURE DR. ROBERT N. WHITLOCK		23B. DATE SIGNED 12/11/65	
23C. PHYSICIAN'S NAME (Type) DR. ROBERT N. WHITLOCK		23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	
24B. DATE DEC. 13, 1965		24C. NAME OF CEMETERY or CREMATORY CHESTNUT GROVE CEM.		24D. LOCATION (City, town, or county) (Stotel) JACKSONVILLE, BALTO. CO., MD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1965		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS John R. ... Son, Towson, Md.	

11-27

MAILED 11-27-62

MATHEW

BALTIMORE, MARYLAND

2400 END HILL

11/10/52

ALABAMA

RECEIVED

MISS ALICE

RECEIVED

ALABAMA

RECEIVED

11/10/52

RECEIVED

RECEIVED

RECEIVED

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11/10/52

11/10/52

11/10/52

RECEIVED

RECEIVED

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

Robert VELTON

2. DATE AND HOUR PRONOUNCED DEAD

Dec. 11, 1965

11:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE

Georgia

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Atlanta

D. STREET ADDRESS (If rural, give location)

2965 S. Pharr Court

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

11-5-1911

9. AGE (In years
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Supervisor

10B. KIND OF BUSINESS OR INDUSTRY

Shell Oil Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John H. Velton

14. MOTHER'S MAIDEN NAME

Katheryn Steadman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Atlanta Ga.

Mrs. William Velton 2965 Pharr Court

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic and hypertensive

(A) ~~coronary~~ cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
Dec. 12, 196523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-14-1965

23C. NAME of CEMETERY or CREMATORY

Parkwood Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Co.

(State)

ADDRESS

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

DEC 10 1965

Robert E. Fagan

Largan Funeral Home 7401 Belair Road

VALLEY POLICE

DEPT. OF JUST

BIRTH NO.

65 12761

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 12761

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

THOMAS

S.

EADER

2. DATE AND HOUR PRONOUNCED DEAD

December 9, 1965

1:15 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Anne Arundel

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Glen Burnie

D. STREET ADDRESS (If rural, give location)

200 A Street, S.W.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

29 Nov. 1902

9. AGE (In years
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Grain Inspector

10B. KIND OF BUSINESS OR INDUSTRY

Balto. Ch. of Com.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas S. Eader

14. MOTHER'S MAIDEN NAME

Bessie Eppler

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

212-03-7589

17. INFORMANT

ADDRESS

Mrs. Myrtle E. Eader (wife) Same as #4

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/10/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

13 Dec. 65

23C. NAME of CEMETERY or CREMATORY

Moreland Memorial Park

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 15 1965

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Robert P. Ware
Singleton Funeral Home/Glen Burnie, Md.

22 Nov. 1952
Mr. J. Edgar Hoover
Director, Federal Bureau of Investigation
Washington, D.C.

Re: [illegible] (Enc. 1) (Info) (S) (P)

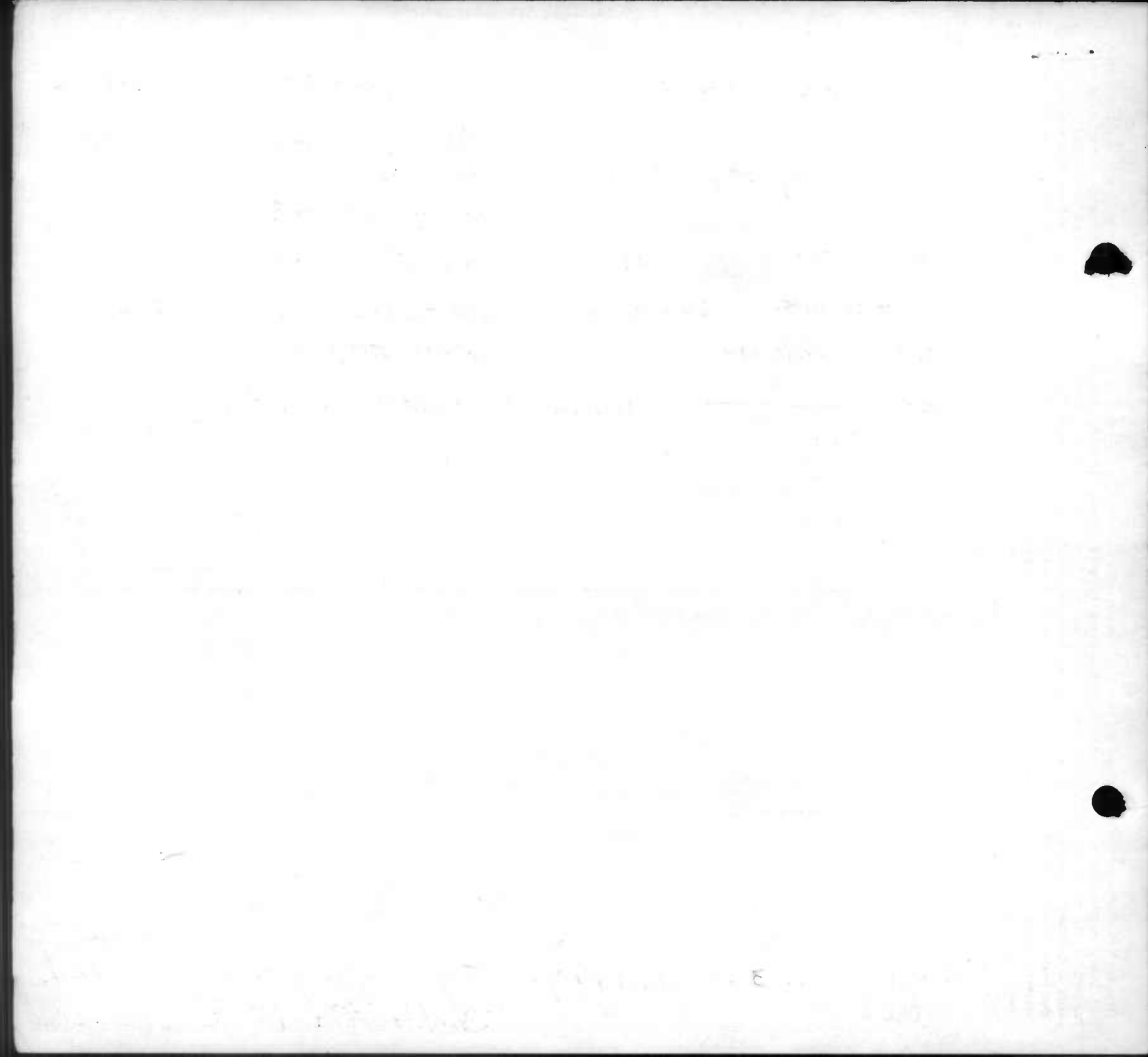
Very truly yours,
[illegible]
Special Agent in Charge

Enclosure (1) (Info) (S) (P)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. <u>65 12762</u>	
BIRTH NO. <u>65 12762</u>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>DIGGS JESSIE</u>		2. DATE AND HOUR OF DEATH <u>12-10-65</u> <u>9:45</u> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u> <u>Baltimore, Md.</u>		A. STATE <u>Md.</u> B. COUNTY <u>ANNE ARUNDEL</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Annapolis</u>			
		D. STREET ADDRESS (If rural, give location) <u>Rt. 4 Box 43</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u>	8. DATE OF BIRTH <u>12-12-09</u>	9. AGE (In years last birthday) <u>55</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Elmer Edman</u>		14. MOTHER'S MAIDEN NAME <u>Jessie Haynes</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>William Diggs (Husband)</u>	
18. <u>163X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>CA. Lung</u> DUE TO (B) <u>Brain Tumor</u> DUE TO <u>metastatic</u> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u> <u>3 mos.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-8</u> 19 <u>65</u> to <u>12-10</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12-10</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Phawatchai Fuangvudhiran</u>				23B. DATE SIGNED <u>12.10.65</u>	
23C. PHYSICIAN'S NAME (Type) <u>THAVATCHAI FUANGVUDHIRAN</u>				23D. ADDRESS <u>University Hospital, Baltimore</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-13-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Pikesville Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Jones</u>		25C. FUNERAL DIRECTOR <u>Robert P. Jones</u>			
25D. ADDRESS <u>Singleton Funeral Home - Glen Burnie, Md.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>65 12763</u>	
BIRTH NO. <u>65 12763</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Mrs. Elizabeth Ciamarra</u>		2. DATE AND HOUR OF DEATH <u>12-11-65</u> <u>9:00 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> , B. COUNTY <u>BALTIMORE</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>35 Church Home & Hospital</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>5300</u>			
D. STREET ADDRESS (If rural, give location) <u>708 Dale Ave.</u>							
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>5-22-08</u>	9. AGE (In years last birthday) <u>57</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>		11. BIRTHPLACE (State or foreign country) <u>Austin W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Tony DiBastiani</u>				14. MOTHER'S MAIDEN NAME <u>Angelina Coccoloni</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>1</u>		17. INFORMANT <u>Anthony E. Ciamarra</u>		ADDRESS <u>714 Dale Avenue 6</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>331X I</u> <u>Intra cerebral hemorrhage</u> DUE TO <u>Hypertension</u> DUE TO <u>?</u> DUE TO <u>?</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12-8</u> 19 <u>65</u> to <u>12-11</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12-11</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>R. J. Maggarity</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12-11-65</u>	
25C. PHYSICIAN'S NAME (Type) <u>Redolfo MAGGARTY</u>				23D. ADDRESS <u>Church Home & Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-14-1965</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1965</u>		25B. NAME OF REGISTRAR <u>R. J. Maggarity</u>		25C. FUNERAL DIRECTOR <u>Church Home & Hospital</u>		ADDRESS <u>7401 Belvoir Road</u> <u>(36)</u>	

Robert H. MAGPANTAY

11 Thompson St

Charles H. H. H. H.

X

10-11-12

65 12764

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12764

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

~~STUART CARLTON SWISHER~~

STUART CARLTON SWISHER

2. DATE AND HOUR PRONOUNCED DEAD

Dec. 10, 1965

4:35 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Dundalk

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Dundalk-Baltimore

D. STREET ADDRESS (If rural, give location)

10 Graywood Rd.

21222

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Feb. 3- 1914

9. AGE (In years
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Presently unemployed

10B. KIND OF BUSINESS OR INDUSTRY

Formerly helped in

11. BIRTHPLACE (State or foreign country)

Penna.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harry Swisher

Produce Stand

14. MOTHER'S MAIDEN NAME

Katheryn Avery

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes,

Navy- 1943-45

16. SOCIAL
SECURITY NO.

206-10-9971

17. INFORMANT

ADDRESS

Wife, Mrs. Margaret Swisher, # 4, a, b, c, d.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Coronary artery sclerosis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Arteriosclerotic heart disease
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Dec. 11, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Dec. 14-1965

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Frederick Rd. Balto. Md. 21228

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 15 1965

JOHN J. DUDA 7922 Wise Ave. Dundalk, Md. 22

VALLEY FORGE

2-11-1942

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH								Registered No.			
BIRTH NO. <u>65 12765</u>											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) <u>Baby-Mills</u> (Boy)						2. DATE AND HOUR OF DEATH <u>12/11/65</u> <u>8:15 AM.</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u> (If not in hospital or institution, give street address or location)						A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>					
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Dundalk</u>					
D. STREET ADDRESS (If rural, give location) <u>7919 St. Clair Lane</u> <u>21222</u>											
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Infant-never married</u>		8. DATE OF BIRTH <u>12/11/65</u>		9. AGE (In years last birthday) <u>—</u>		10. Under 1 Yr. Months: Days		11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jay Mills</u>						14. MOTHER'S MAIDEN NAME <u>Betty Wiley</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT ADDRESS <u>Father, Mr. Jay Mills, # 4,a,b,c,d.</u>							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) <u>Fetal Anoxia</u> DUE TO				INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
						(B) <u>Premature Separation of Placenta</u> DUE TO					
				(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Louis C. Gareis</u> M.D.								Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>Dec. 11-1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>LOUIS C. GAREIS</u>				23D. ADDRESS <u>819 MEDICAL ARTS BLD.</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Dec-13-1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>Oak Lawn</u>				24D. LOCATION (City, town, or county) (State) <u>7225 Eastern Ave. Balto. Md. 21224</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1965</u>				25B. NAME OF REGISTRAR <u>John J. Duda</u>				25C. FUNERAL DIRECTOR ADDRESS <u>7922 Wise Ave. Dundalk, Md. 22</u>			

Wm. J. Miller
Bottling W. J. Miller

2nd W. J. Miller

Wm. J. Miller
Bottling W. J. Miller

No

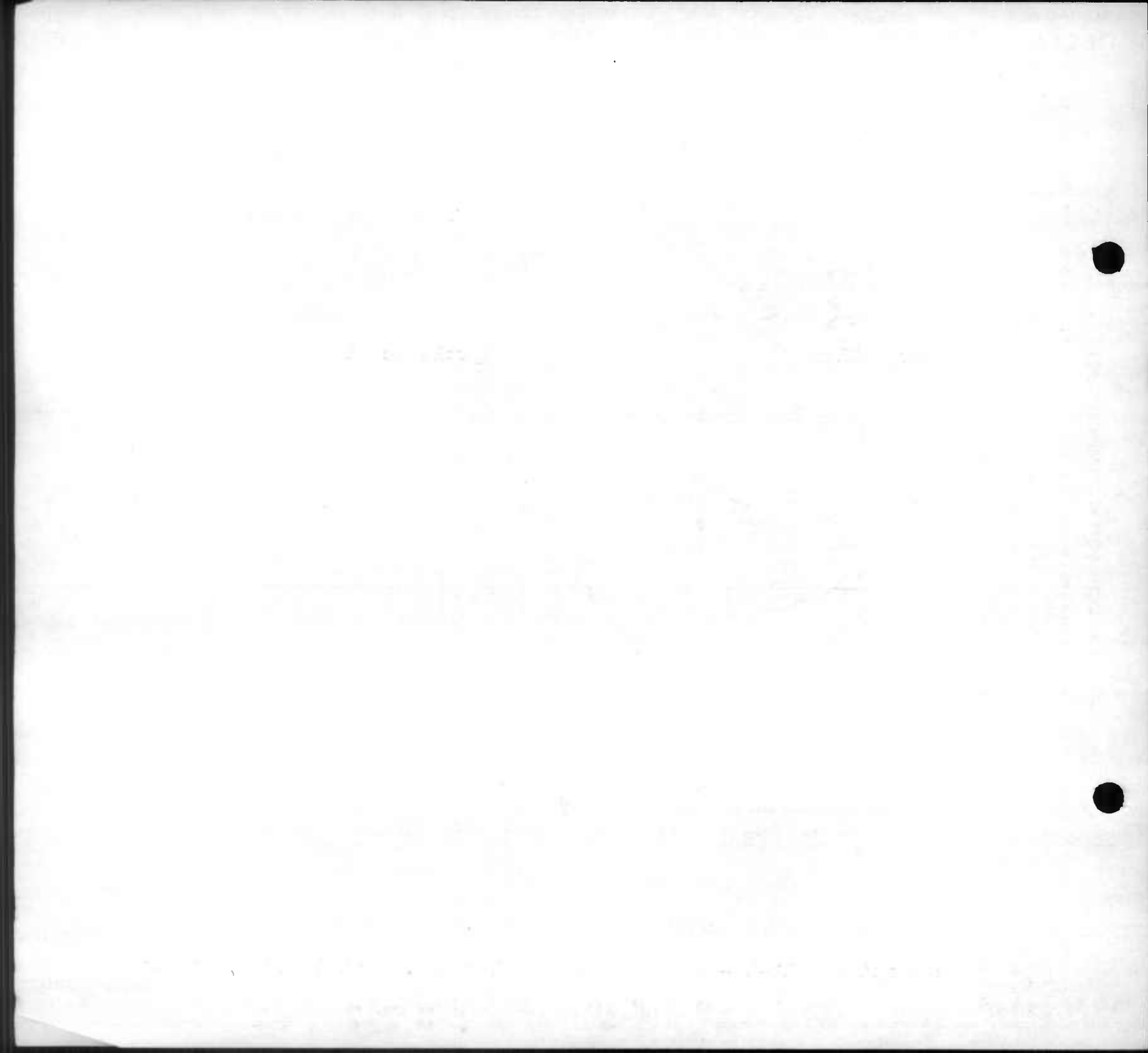
814 MEDICAL ARTS LTD

Wm. J. Miller
Bottling W. J. Miller

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No.	
BIRTH NO. 65 12766		M.E. CASE NO. 65 12766		2. DATE AND HOUR OF DEATH 12/14/65 15 ¹⁸ A.M.			
1. NAME OF DECEASED (Type or Print) ALLEN, BABY GIRL							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Md Baltimore			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 909			
				D. STREET ADDRESS (If rural, give location) 1324 Asquith Street			
5. SEX F	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 12/11/65	9. AGE (In years last birthday) 3	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry Allen				14. MOTHER'S MAIDEN NAME Myrtle Echol			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. 761.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osseous, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) 1 ^o apnea DUE TO (B) ABRUPTIO PLACENTA DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/11/65 to 12/14/65, that (I) (we) last saw the deceased alive on 12/14/65 and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jerry Winkelstein				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/14/65	
23C. PHYSICIAN'S NAME (Type) Jerry Winkelstein				23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) cremation		24B. DATE 12-14-65		24C. NAME OF CEMETERY or CREMATORY The Johns Hopkins Hos.		24D. LOCATION (City, town, or county) (State) Baltimore 5, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1965		25B. NAME OF REGISTRAR R. E. F. Jones		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 5435 65 12767		BALTIMORE CITY HEALTH DEPT. CERTIFICATE OF DEATH		Registered No. 65 12767	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Seldon, Jack P.		2. DATE AND HOUR OF DEATH 12/10/65 6:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland (Glencoe) B. COUNTY Glencoe, Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital		D. STREET ADDRESS (If rural, give location) 4210 Clark Drive Ensor Mill Road		53-00	
5. SEX Male	6. RACE W	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (Specify)	8. DATE OF BIRTH 2/4/46	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXECUTIVE		10B. KIND OF BUSINESS OR INDUSTRY FOOD PACKING		11. BIRTHPLACE (State or foreign country) England	
13. FATHER'S NAME UNKNOWN JOHN SELDON		14. MOTHER'S MAIDEN NAME UNKNOWN MAUDE BLACKWHITE		12. CITIZEN OF WHAT COUNTRY? U.S.A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT WM. SELDON ADDRESS HOME ENSOR MILL ROAD GLENCOE, MARYLAND	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease or injury or complication which caused death.) Aspiration Pneumonia		CAUSE OF DEATH Aspiration Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, which rise to the above cause (A) stating UNDERLYING CONDITION last. Delirium Tremens		DUE TO Delirium Tremens		2 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Liver Disease		DUE TO Chronic Liver Disease		10-15 yrs.	
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) None		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unknown		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Unknown	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 12/6/65		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Automobile (Unknown)	
22. I certify that (I) (this hospital) attended the deceased from 12/6/65 19 65 to 12/10/65 19 65 , that (I) (we) last saw the deceased alive on 12/10/65 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael Lee Levin				23B. DATE SIGNED 10 Dec 65	
23C. PHYSICIAN'S NAME (Type) MICHAEL L. LEVIN		23D. ADDRESS M.D. SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12, 13, 65		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley	
24D. LOCATION Towson, Md. #4		24E. NAME OF CEMETERY or CREMATORY Towson, Md. #4		24F. LOCATION Towson, Md. #4	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1965		25B. NAME OF REGISTRAR Wm. Cook-Brooks		25C. FUNERAL DIRECTOR Wm. Cook-Brooks	
25D. ADDRESS 1050 YORK RD.		25E. ADDRESS 1050 YORK RD.		25F. ADDRESS 1050 YORK RD.	

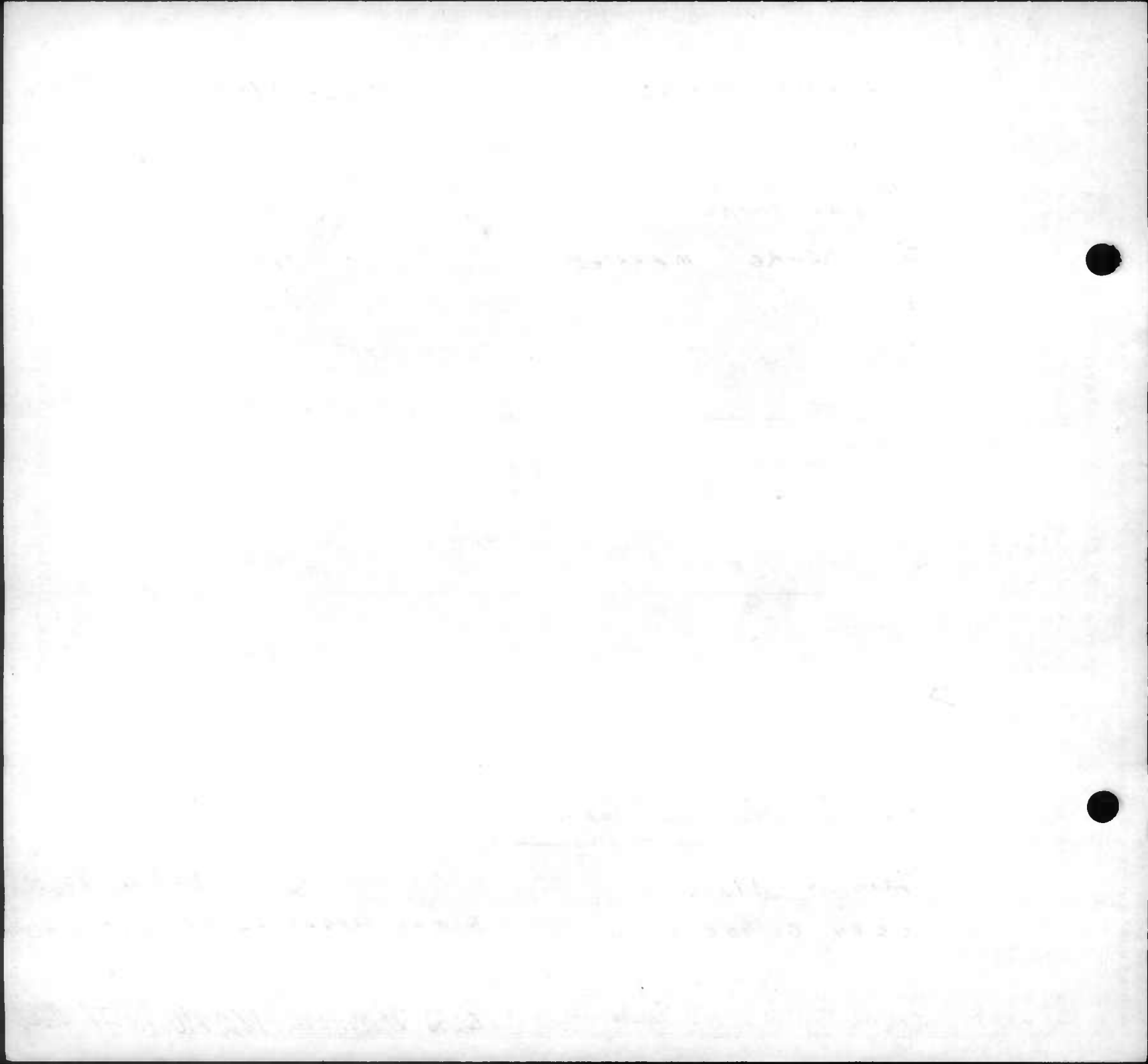


run med 12/14/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12768	
BIRTH NO. 65 12768		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WICKS, AGNES		2. DATE AND HOUR OF DEATH 14 DEC. 1965 10 35 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY 27-14		
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 4711 Falls Road		
5. SEX F	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH Dec. 15-1893	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Co. Md.	
13. FATHER'S NAME Elisha Scott			12. CITIZEN OF WHAT COUNTRY?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 220-03-8097B		17. INFORMANT ADDRESS Leon Wicks - 4711 Falls Rd.
18. 42011 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) acute myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. arteriosclerotic cardiovascular disease			CAUSE OF DEATH (A) acute myocardial infarction DUE TO (B) arteriosclerotic cardiovascular disease DUE TO diuretic (C)		
INTERVAL BETWEEN ONSET AND DEATH 4 hrs.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that he (this hospital) attended the deceased from 14 DEC 1965 to 14 DEC 1965 , that he (we) last saw the deceased alive on 14 Dec 1965 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Leon S. Sheer				23B. DATE SIGNED 14 Dec. 1965	
23C. PHYSICIAN'S NAME (Type) LEON G. SHEER, M.D.				23D. ADDRESS SINAI HOSPITAL OF BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec 18, 1965		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem.	
24D. LOCATION (City, town, or county) Balto.		24E. STATE Md			
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1965		25B. NAME OF REGISTRAR Robert E. Galt, M.D.		25C. FUNERAL DIRECTOR ADDRESS Barb Wilmore - 1827 W. North Ave	



65 12769

BALTIMORE CITY HEALTH DEPARTMENT

65 12769

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HANNA BAXLEY

2. DATE AND HOUR PRONOUNCED DEAD

12/14/65 5:35 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1711 W. Lanvale St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

82

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Edward Hicks

14. MOTHER'S MAIDEN NAME

Anna Hicks

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

Rosetta Harper

ADDRESS

1711 W. Lanvale St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)Arteriosclerotic cardiovascular disease
(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/15/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Dec. 18, 1965

23C. NAME of CEMETERY or CREMATORY

Lowenberg Court House

23D. LOCATION

(City, town, or county)

(State)

Kimbridge Virginia

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

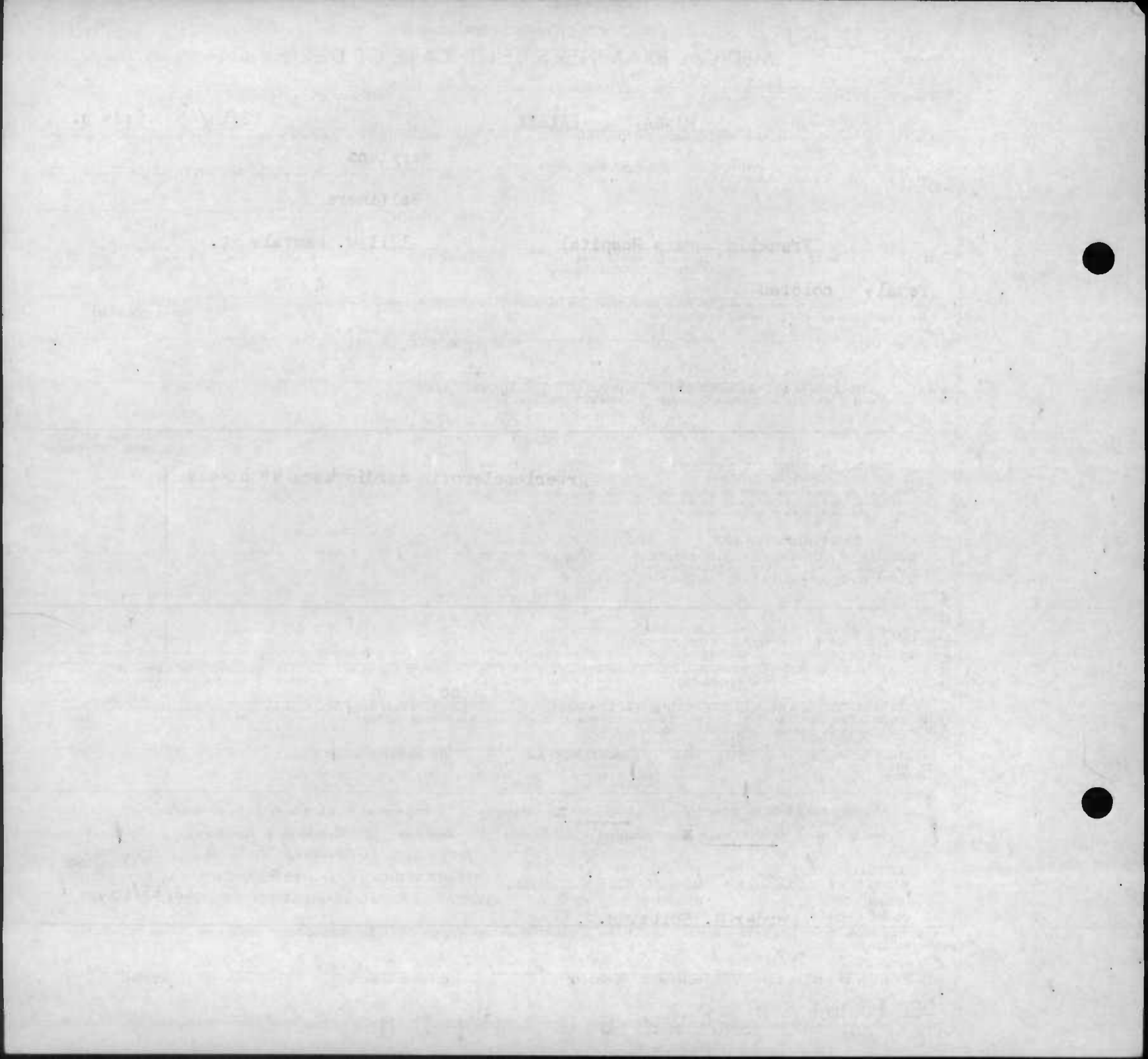
24C. FUNERAL DIRECTOR

ADDRESS

DEC 15 1965

P.O. Box 1000

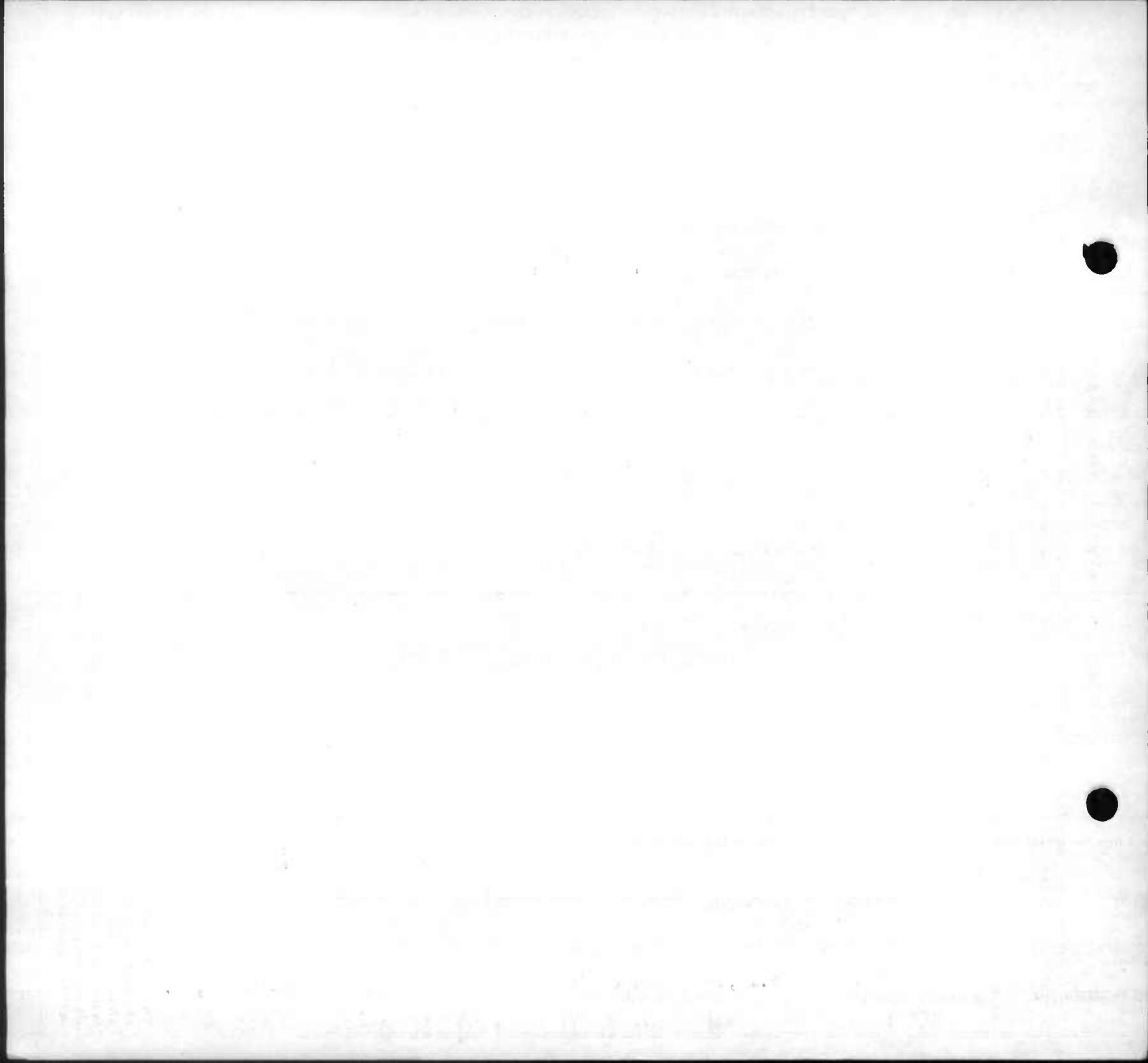
Carl H. Moore - 1527 N. North Ave



FUNERAL DIRECTOR: IMPORTANT

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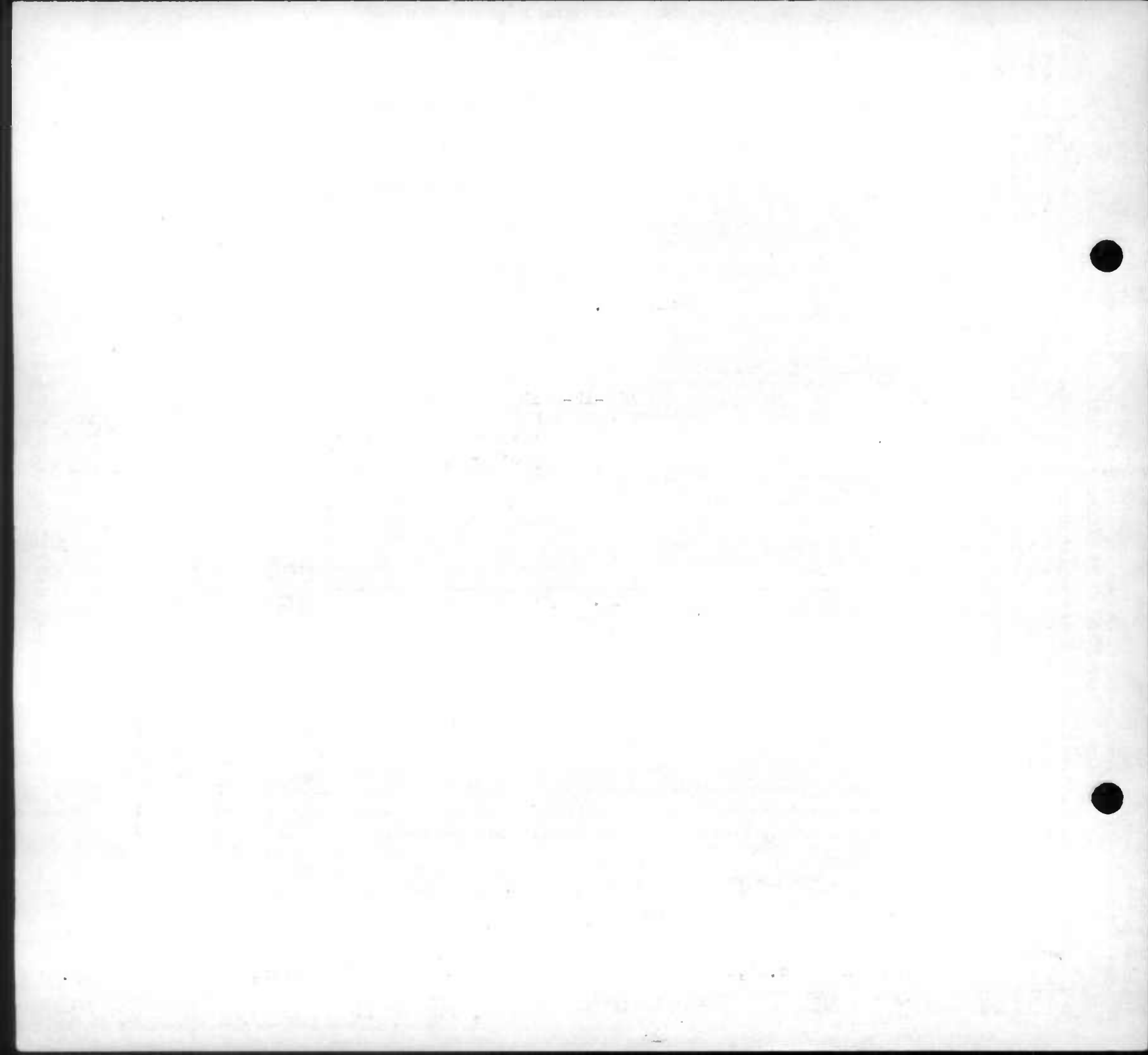
BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 65 12770	
BIRTH NO. 65 12770											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) JOHN B. HENNELLY						2. DATE AND HOUR OF DEATH 12-14-65 8:45 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 10-01					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LITTLE SISTERS OF THE POOR 1200 VALLEY STREET BALTIMORE, MD. 21202						C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE					
D. STREET ADDRESS (If rural, give location) 1200 VALLEY STREET											
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 7-16-1891	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MARINER				10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MT. HOLLEY, VIRGINIA			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JAMES HENNELLY						14. MOTHER'S MAIDEN NAME MARGARET ANTHONY					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN				16. SOCIAL SECURITY NO. 217-07-8529A		17. INFORMANT LITTLE SISTERS OF THE POOR			ADDRESS 1200 VALLEY STREET BALTIMORE, MD. 21202		
18. 422.1 I											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH											
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)											
ANTECEDENT CAUSES											
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12.12.1964 to 12.14.1965 ; that (I) (we) last saw the deceased alive on 12.14.1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Stanley Ankudars M.D.								Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12.15.65	
23C. PHYSICIAN'S NAME (Type) STANLEY ANKUDARS M.D.								23D. ADDRESS 1802 W. Bost & Bosto Md 21223			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE Dec. 18, 1965		24C. NAME OF CEMETERY or CREMATORY Loudon Park			24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1965				25B. NAME OF REGISTRAR R. B. P. Jenkins				25C. FUNERAL DIRECTOR Wm. J. Jenkins & Sons. N.Y. Pa. Ave.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12771	
BIRTH NO. 65 12771		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WADE FRED C.			
2. DATE AND HOUR OF DEATH 13 Dec 65 5:50 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 11-03			
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 844 N Eutaw St			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-17-11	9. AGE (In years last birthday) 54	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CORETAKER		10B. KIND OF BUSINESS OR INDUSTRY Realty Co.		11. BIRTHPLACE (State or foreign country) Kentucky	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME BRUCE WADE		14. MOTHER'S MAIDEN NAME Luna Walker	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. 407-12-8412		17. INFORMANT wife ADDRESS 825 N Eutaw St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 493X I		CAUSE OF DEATH Influenza Dehydration Alcoholism		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Dehydration			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (X) (this hospital) attended the deceased from 9-Dec 1965 to 13-Dec 1965 , that (X) (we) last saw the deceased alive on 13-Dec 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE T.C. Cullis MD		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 13-Dec-65	
23C. PHYSICIAN'S NAME (Type) T.C. Cullis MD		23D. ADDRESS Maryland General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE Dec. 16, 1965		24C. NAME OF CEMETERY or CREMATORY Winchester, Ky.	
24D. LOCATION (City, town, or county) (State)		25A. DATE RECEIVED BY HEALTH DEPT. DEC 15 1965		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR Wm. D. Pickner & Sons		ADDRESS 714 Pa. Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. <u>65 12772</u>					
BIRTH NO. <u>65 12772</u>		M.E. CASE NO. <u>65 12772</u>			2. DATE AND HOUR OF DEATH <u>12 DECEMBER 1965 2:15 A.M.</u>					
1. NAME OF DECEASED (Type or Print) <u>TAYLOR, DANIEL O.</u>					4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>St. Mary's</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIVERSITY HOSPITAL</u>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>HOLLYWOOD</u> D. STREET ADDRESS (If rural, give location) <u>65-00</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>15 MAY 1908</u>	9. AGE (In years last birthday) <u>57</u>	If Under 1 Yr. Months: Days: Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electronic Technician</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Civil Service</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>TAYLOR, Osmond P.</u>					14. MOTHER'S MAIDEN NAME <u>Myrtle V. Wilkins</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Chart</u>				ADDRESS	
18. <u>451X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
					(A) <u>Dissecting aortic aneurysm</u> DUE TO		<u>32 hrs</u>			
					(B) <u>Hypertensive cardiovascular dis</u> DUE TO		<u>20+ yrs</u>			
					(C) <u>acute aortic insufficiency</u>		<u>8 hrs</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>NONE</u>										
19A. DATE OF OPERATION <u>0 NONE</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>11 Dec 7pm</u> 19 <u>65</u> to <u>12 Dec 2:15 am</u> 19 <u>65</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>12 Dec 2:30 am</u> 19 <u>65</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.										
23A. SIGNATURE <u>Barbara L. Johnson</u> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>12 Dec 65</u>		
23C. PHYSICIAN'S NAME (Type) <u>Barbara L. Johnson</u> M.D.					23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/15/65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Trinity Memorial</u>		24D. LOCATION (City, town, or county) <u>Waldorf, Charles</u>		(State) <u>md</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1965</u>			25B. NAME OF REGISTRAR <u>R. E. Johnson</u>		25C. FUNERAL DIRECTOR <u>W. C. B. Mattingley, Leonardtown md.</u>					

W. W. A.

George P.

George P.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 65 12773					CERTIFICATE OF DEATH					
M.E. CASE NO.					Registered No. 65 12773					
1. NAME OF DECEASED (Type or Print) DORA ANN COLLINS					2. DATE AND HOUR OF DEATH 12-14-65 7²⁰ A. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 18-02					
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL (If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE					
					D. STREET ADDRESS (If rural, give location) 1122 W. LEXINGTON ST.					
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED		8. DATE OF BIRTH 6-18-62	9. AGE (In years last birthday) 3	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME FALCON CARLE					14. MOTHER'S MAIDEN NAME DOROTHY A. COLLINS					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT Dorothy Collins			ADDRESS Same		
18. 754.51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) PNEUMONIA					CAUSE OF DEATH (A) DUE TO CONGENITAL HEART DISEASE					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					INTERVAL BETWEEN ONSET AND DEATH 4 DAYS					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					NO					
19A. DATE OF OPERATION NO			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12-12-1965 to 12-14-1965 , that (I) (we) lost saw the deceased olive on 12-14-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE John C. Copley					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 12-14-65		
23C. PHYSICIAN'S NAME (Type) John C. Copley					23D. ADDRESS UNIVERSITY HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 12-15-65		24C. NAME OF CEMETERY or CREMATORY McLachlan Cent			24D. LOCATION (City, town, or county) (State) Brooklyn Md		
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1965			25B. NAME OF REGISTRAR RECEIVED			25C. FUNERAL DIRECTOR 304			ADDRESS	

1000

1000

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

BLANCHE WILLIAMS

2. DATE AND HOUR PRONOUNCED DEAD

12/15/65 7:20 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1040 W. Franklin St.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1040 W. Franklin St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

August 10 - 1883

9. AGE (In years
last birthday)

82

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Williams

14. MOTHER'S MAIDEN NAME

Elizabeth ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Metastatic carcinoma of breast

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/15/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 15 1965

Ruth E. Johnson

Chey Wilson 1001 Beatty Ave

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10/1/80 BY SP-6 JAC/STP

REASON FOR DECLASSIFICATION

DATE 10/1/80 BY SP-6 JAC/STP

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 12775

BIRTH NO. 65 12775		CERTIFICATE OF DEATH		Registered No. 65 12775	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) HARRY CONRAD ZULAUF		2. DATE AND HOUR OF DEATH 12/13/65		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 9-07		5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK (RET)		10B. KIND OF BUSINESS OR INDUSTRY BALTIMORE, MARYLAND		8. DATE OF BIRTH 9/27/76 9. AGE (In years last birthday) 89	
13. FATHER'S NAME CONRAD ZULAUF		14. MOTHER'S MAIDEN NAME WILHELMINA FLECKENSTEIN		11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK NO		16. SOCIAL SECURITY NO. 213 05 6766		17. INFORMANT NORMAN ZULAUF 944 BOLTON LA. ROCKLEDGE, FLA Mr. Edward C. Zulauf	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH H004 Ridge Top Rd Richmond Va. (A) DUE TO Broncho pneumonia (B) DUE TO (C) JNC		19. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work [] Not While At Work []		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/13 1965 to 12/13 1965 that (I) (we) last saw the deceased alive on 12/13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles S. Brown		M.D. Attending Phys. [] Med. Director [] Staff Phys. [x]		23B. DATE SIGNED 12/13/65	
23C. PHYSICIAN'S NAME (Type) CHARLES S. BROWN		23D. ADDRESS M.D. UNION MEMORIAL HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/16/65		24C. NAME OF CEMETERY or CREMATORY Woodlawn	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1965		25B. NAME OF REGISTRAR J. A. J. 0		25C. FUNERAL DIRECTOR HENRY SANDER & SONS INC. BALTIMORE MARYLAND 21213	



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W-420

65 12776 BALTIMORE CITY HEALTH DEPARTMENT MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12776

BIRTH NO. M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) MARGARET H.E. WELSH 2. DATE AND HOUR PRONOUNCED DEAD 12-13-65 8:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL - DOA 5. SEX Female 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 8. DATE OF BIRTH April 23, 1923 9. AGE (In years last birthday) 42 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Ramsay 14. MOTHER'S MAIDEN NAME Gertrude Norwood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No None 16. SOCIAL SECURITY NO. ? 17. INFORMANT EARL WELSH, SR. 3574 BENZINGER RD ADDRESS

18. CAUSE OF DEATH 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C)

19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER [X] DATE SIGNED 12-13-65

ACTUAL SIGNATURE EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D. M.D. ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 12-16-65 23C. NAME OF CEMETERY or CREMATORY Baltimore National 23D. LOCATION (City, town, or county) Baltimore, Md

24A. DATE REC'D BY HEALTH DEPT. DEC 15 1965 24B. NAME OF REGISTRAR 24C. FUNERAL DIRECTOR GEO. L. SCHWAB Funeral Home 24D. ADDRESS 2101 Rutland Ave.

VS 151-REV. 1/1/65

VALLEY FORD

PAID TO ORDER

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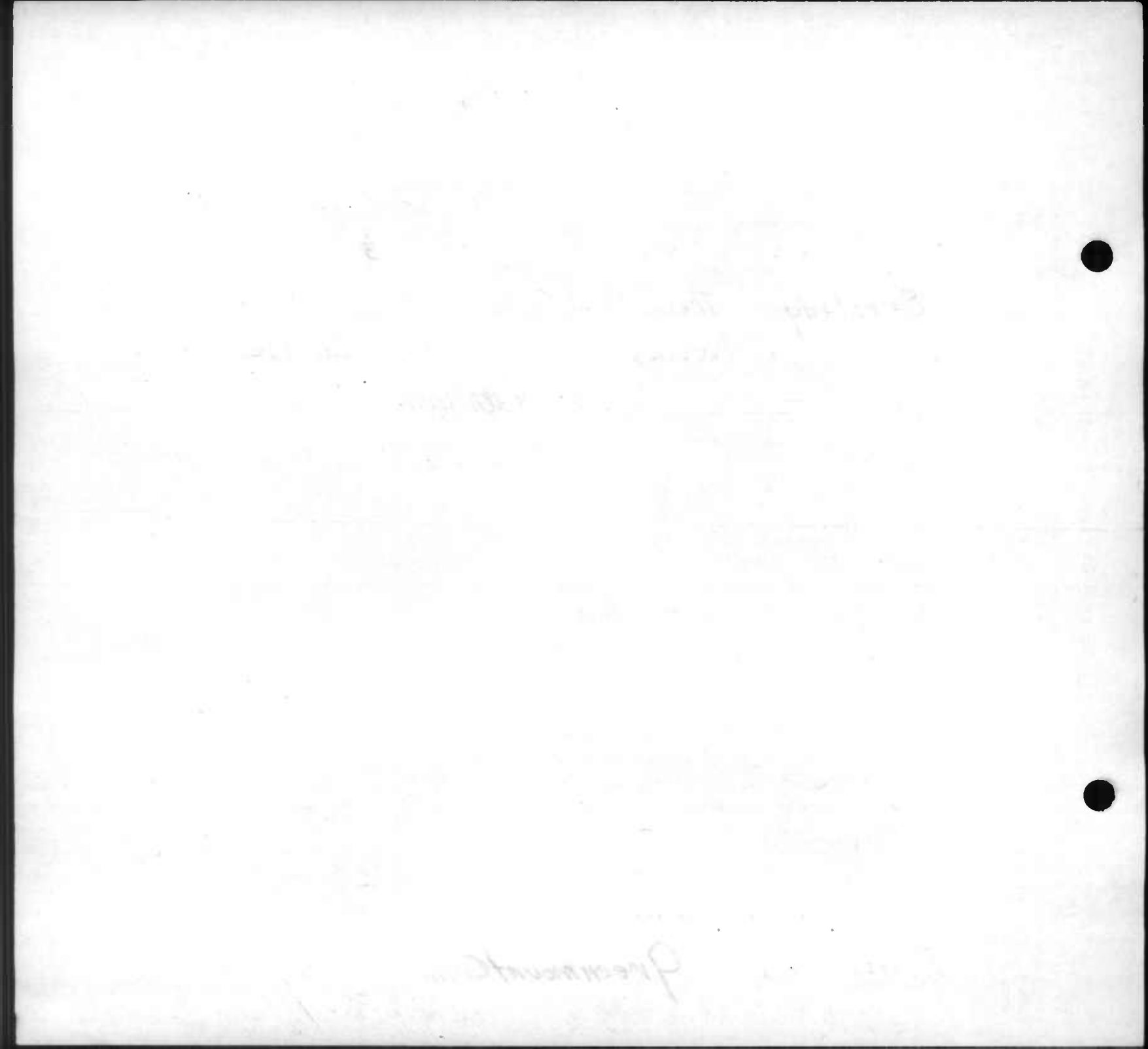
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT												
CERTIFICATE OF DEATH					Registered No. <u>65 12777</u>							
BIRTH NO. <u>65 12777</u>		M.E. CASE NO. <u>65 12777</u>			1. NAME OF DECEASED (Type or Print) <u>Marie Ethel O'Connor</u>					2. DATE AND HOUR OF DEATH <u>12/11/65 12 55 P.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>Union Memorial Hosp</u> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-14</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>4525 Reswick Road</u>							
5. SEX <u>Female</u>		6. RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>		8. DATE OF BIRTH <u>9/8/93</u>		9. AGE (In years last birthday) <u>72</u>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done most of working life, even if retired) <u>Sales lady</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Theater Candy Counter</u>				11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Joseph Nevins</u>					14. MOTHER'S MAIDEN NAME <u>IDA Louise King</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>216288129</u>		17. INFORMANT <u>William J. O'Connor</u> ADDRESS <u>4525 Reswick Rd</u>						
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>332XI</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) <u>Cerebral Vascular Thrombosis</u> DUE TO (B) _____ DUE TO (C) _____					INTERVAL BETWEEN ONSET AND DEATH <u>11/3/65 - 12/1/65</u>		
MEDICAL CERTIFICATION												
19A. DATE OF OPERATION <u>N/A</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>				20A. AUTOPSY? (Yes or No) <u>N/A</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>N/A</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>N/A</u>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>N/A</u>				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>N/A</u>				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>N/A</u>				21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input checked="" type="checkbox"/> <u>N/A</u>				21F. HOW DID INJURY OCCUR? <u>N/A</u>				
22. I certify that (1) (this hospital) attended the deceased from <u>12/11/65</u> 19 <u>65</u> to <u>12/11/65</u> 19 <u>65</u> that (2) (we) last saw the deceased alive on <u>12/11/65</u> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.												
23A. SIGNATURE <u>Harry J. Brown</u> M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>										23B. DATE SIGNED <u>12/1</u>		
23C. PHYSICIAN'S NAME (Type) <u>DR. HARRY J. BROWN</u> M.D.										23D. ADDRESS _____		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>15 Dec 65</u>		24C. NAME of CEMETERY or CREMATORY <u>Greenmount Cem.</u>			24D. LOCATION (City, town, or county) (State) <u>Balto., Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1965</u>				25B. NAME OF REGISTRAR <u>R. B. E. [unclear]</u>				25C. FUNERAL DIRECTOR <u>Burial & Funeral Home</u>		ADDRESS <u>3631 Falk Rd</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 12778	
BIRTH NO. 65 12778		M.E. CASE NO. 65 12778		1. NAME OF DECEASED (Type or Print) RACHAEL O'ROURKE		2. DATE AND HOUR OF DEATH 12/12/65 1 49 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-15			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hosp. of Balto, Inc				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 5922 Smith Avenue			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED Married	8. DATE OF BIRTH Oct 30 1920		9. AGE (In years last birthday) 45	10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frank Bacon				14. MOTHER'S MAIDEN NAME Mary Londerree			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Thomas C O'Rourke		ADDRESS 5922 Smith Ave	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction				CAUSE OF DEATH (A) DUE TO Hypertensive Arterio Sclerotic Cardio-Vasc. Disease		INTERVAL BETWEEN ONSET AND DEATH 1 day	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. No							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) No		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) No		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that we (this hospital) attended the deceased from 12/12/65 to 12/12/65 , that we (we) last saw the deceased alive on 12/12/65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. we (We) (did) did not view the body after death.							
23A. SIGNATURE J. S. Weinstock				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/12/65	
23C. PHYSICIAN'S NAME (Type) Sinai Hosp. of Balto, Inc.				23D. ADDRESS Sinai Hosp. of Balto, Inc.			
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 16 Dec 65		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cem		24D. LOCATION (City, town, or county) (State) Pikesville, Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1965		25B. NAME OF REGISTRAR R. E. B. B. B.		25C. FUNERAL DIRECTOR Burial & Funeral Home		ADDRESS 3431 Falls Rd	

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

JOHN E. REIP

2. DATE AND HOUR PRONOUNCED DEAD

12-13-65

12:35 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)SOUTH BALTIMORE GENERAL HOSPITAL
DOA

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

Anne Arundel

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

1016 Beach Promenade

D. STREET ADDRESS (If rural, give location)

ORCHARD BEACH

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

APRIL 15, 1898

9. AGE (In years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Carpenter

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Joseph Reip

14. MOTHER'S MAIDEN NAME

Catherine Bawersck

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

16. SOCIAL
SECURITY NO.

17. INFORMANT

Family

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A).....
DUE TO

Arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B).....
DUE TO

(C).....

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-13-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-16-65

23C. NAME of CEMETERY or CREMATORY

Oton Haven Cem.

23D. LOCATION

(City, town, or county)

(State)

Oton Bume, Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 15 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

McCully Funeral Home 237 Pikesville

WALKER FORGE

OLD COUNTRY

CERTIFICATE OF DEATH

Registered No. 65 12780

BIRTH NO.

65 12780

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Vincent Lyons W. VINCENT LYONS

2. DATE AND HOUR OF DEATH

12-10-65

1130 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland, #212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2010 Homewood Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
NEVER MARRIED

8. DATE OF BIRTH

9-13-1876

9. AGE (In years
last birthday)

89

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTO., MD.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

PATRICK LYONS

14. MOTHER'S MAIDEN NAME

MARY O'SULLIVAN

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH, 4940 Eastern Ave., #21224

18. 5-76X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Peritonitis

Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO

(?) Bronchopneumonia

Unknown

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

GI hemorrhage ? 5 ft

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-10-65 to 12-10-65
that (I) (we) last saw the deceased alive on 12-10-65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Robert Kent

M.D.

Attending
Phys. ☐Med.
Director ☐Intern
Staff
Phys. ☒

23B. DATE SIGNED

12-10-65

23C. PHYSICIAN'S
NAME (Type)

Robert R. Kent

M.D.

23D. ADDRESS

Baltimore City Hospitals

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION
(City, town, or county)

(State)

BURIAL

12-14-65

CATHEDRAL CEMETERY BALTO., MD

25A. DATE REC'D BY HEALTH DEPT.

DEC 16 1965

25B. NAME OF REGISTRAR

Robert E. Kent

25C. FUNERAL DIRECTOR

J. Walter Conklin 5444 BELAIR RD

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

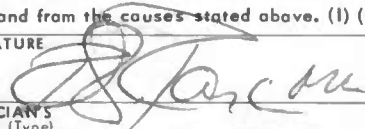
Male White

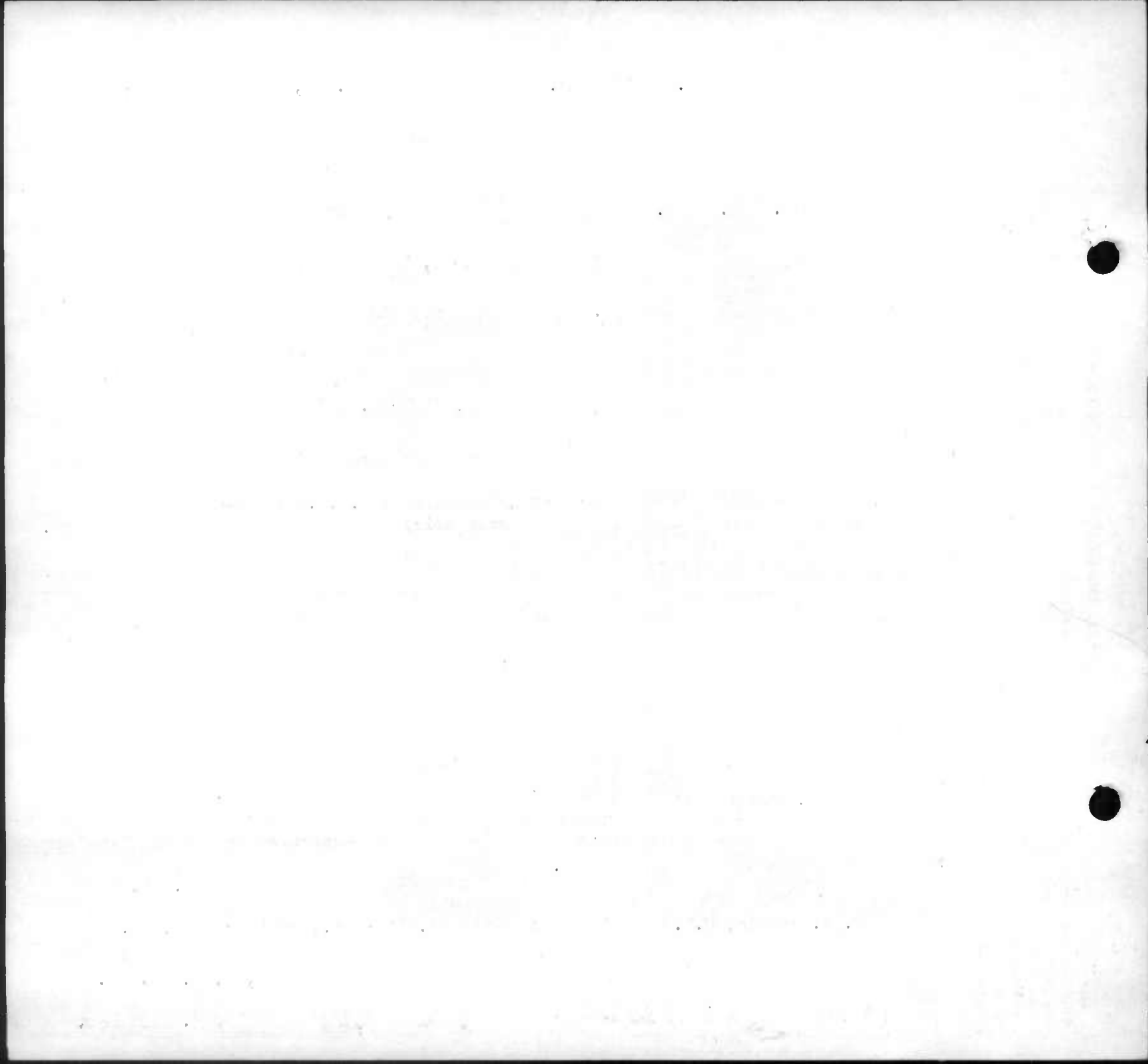
84

RECORDS: BCH, 4940 Eastern Ave., #51554

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

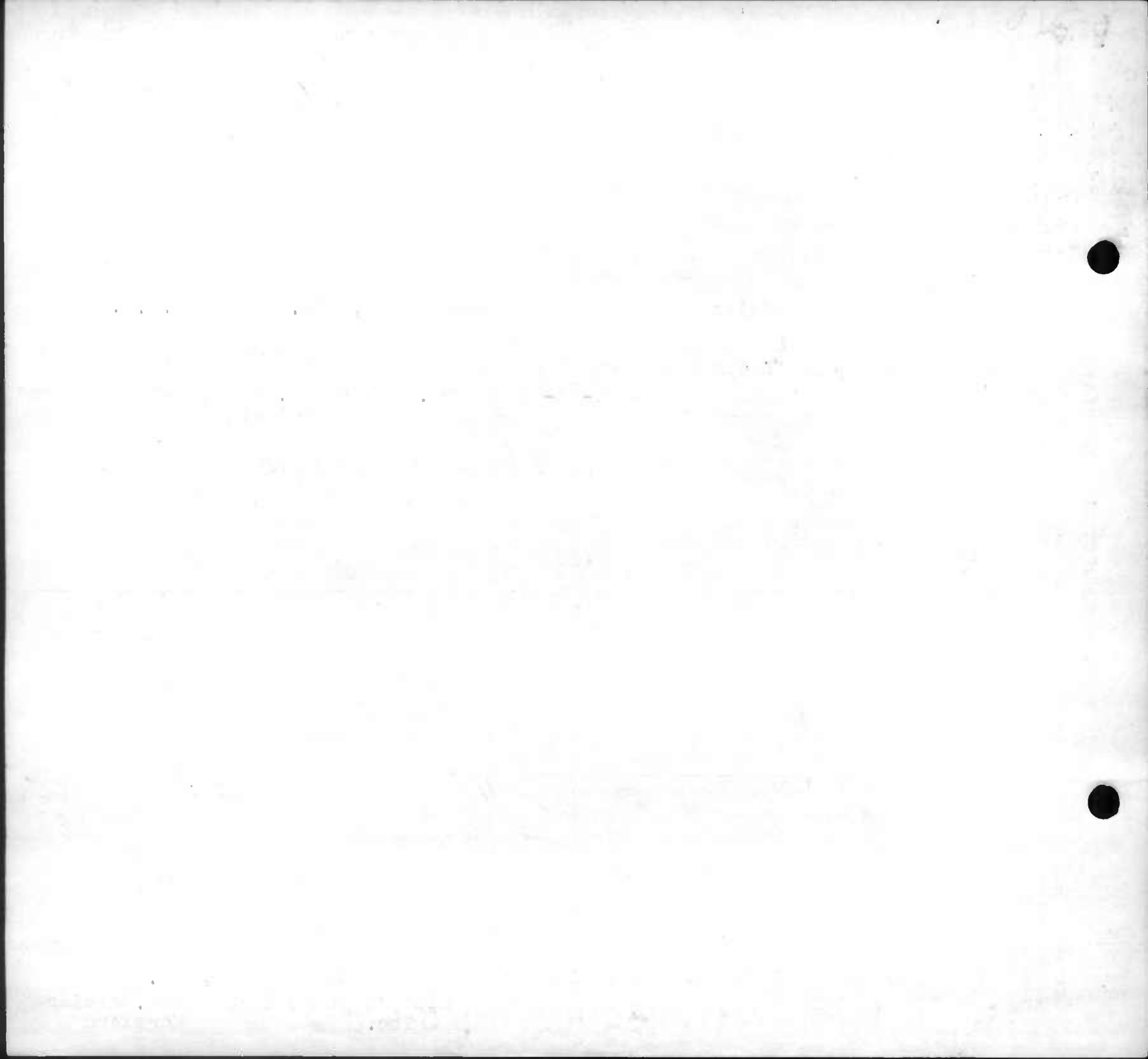
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 12781				
BIRTH NO. 65 12781					2. DATE AND HOUR OF DEATH Dec. 14, 1965 12:05 A M.				
M.E. CASE NO. 65 12781									
1. NAME OF DECEASED (Type or Print) Ivan B. White Sr.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Balto. Gen. Hosp.					A. STATE Maryland				
					B. COUNTY Baltimore				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 1616 Elkins Lane				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH June 2, 1918	9. AGE (In years last birthday) 47	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor Foreman		10B. KIND OF BUSINESS OR INDUSTRY Steel Co.		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Jesse White					14. MOTHER'S MAIDEN NAME Jeanette Davis				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Viola M. White		ADDRESS 1616 Elkins Lane		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute coronary thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) DUE TO Arteriosclerotic C.V.D. (Atherosclerosis) (B) DUE TO sclerosis (C) _____		INTERVAL BETWEEN ONSET AND DEATH 4 minutes 9 1/2 yrs.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 19 54 to Dec. 14 19 65 , that (I) (we) last saw the deceased alive on December 10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. Approved by Medical Examiner									
23A. SIGNATURE 					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED Dec. 14, 1965	
23C. PHYSICIAN'S NAME (Type) R. V. Rangle, M.D.					23D. ADDRESS M.D. 2938 St. Paul St., Baltimore 18, Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12 17 65		24C. NAME OF CEMETERY or CREMATORY Glen Haven		24D. LOCATION (City, town, or county) (State) Glen Burnie, A. A. Co. Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 16 1965		25B. NAME OF REGISTRAR R. V. Rangle		25C. FUNERAL DIRECTOR 130 E. Fort Ave.		ADDRESS 130 E. Fort Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

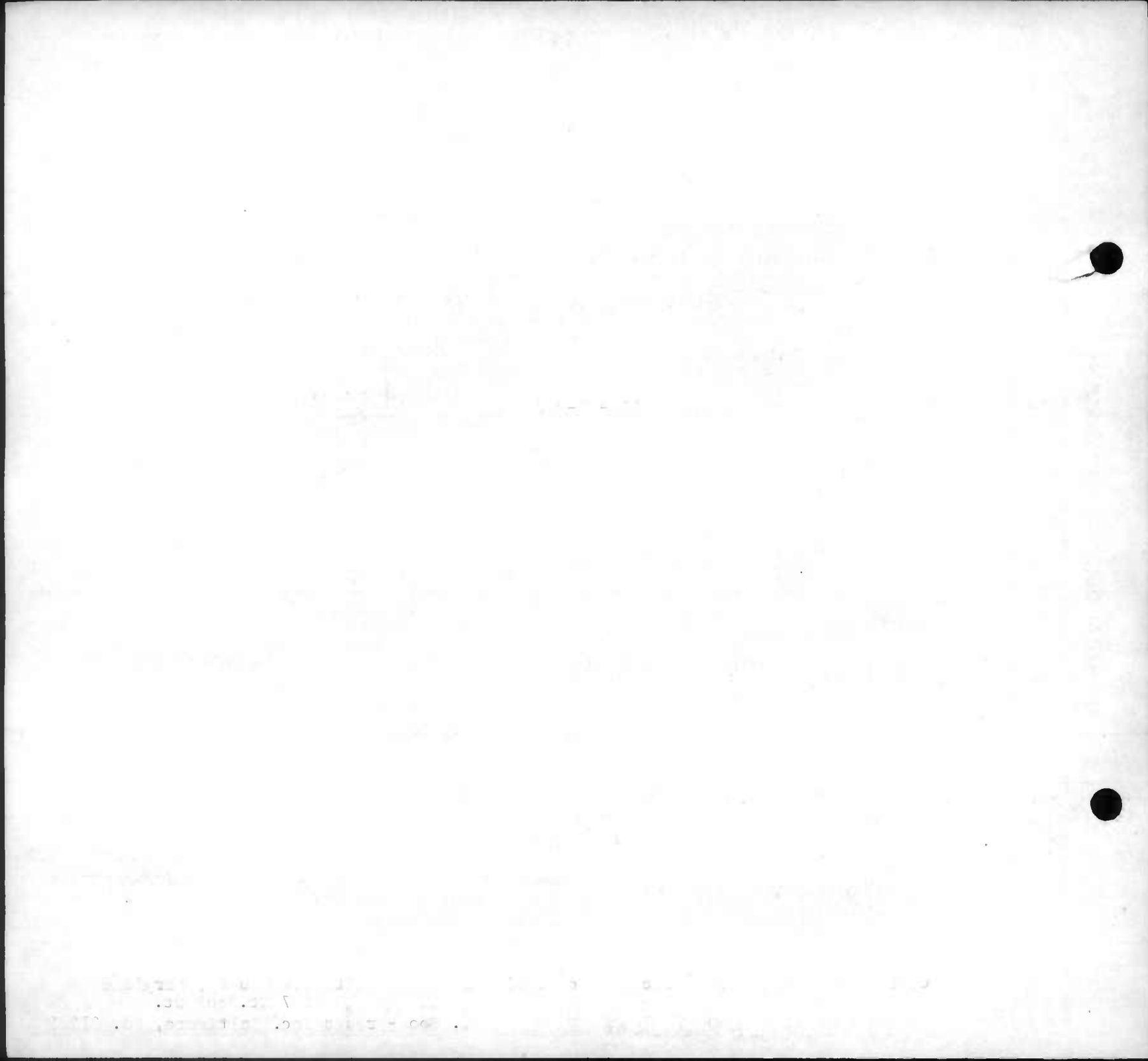
BALTIMORE CITY HEALTH DEPARTMENT											
BIRTH NO. 65 12782 CERTIFICATE OF DEATH Registered No. 65 12782											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) WILLIAM BUSBY						2. DATE AND HOUR OF DEATH 12/10/65 4:15 A M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND PRINCE GEORGE					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL						C. CITY OR TOWN (If outside city limits, write RURAL and give township) LANDOVER 66-00					
D. STREET ADDRESS (If rural, give location) 9021 TAYLOR STREET											
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 6-6-19		9. AGE (In years lost birthday) 46		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dental Technician				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Birmingham, Ala.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES G. BUSBY						14. MOTHER'S MAIDEN NAME DELLA SAYLOR					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII				16. SOCIAL SECURITY NO. 421-05-0364		17. INFORMANT ADDRESS Mrs. Dorothy J. Busby (above address (wife))					
18. 710.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) SCLERODERMA-LIKE DISEASE CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 5 months											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from 11/12/65 to 12/11/65 that (I) (we) last saw the deceased alive on 12/11/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
23A. SIGNATURE William B. Cutts						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/11/65			
23C. PHYSICIAN'S NAME (Type) WILLIAM B. CUTTS						23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12/14/65		24C. NAME OF CEMETERY or CREMATORY Fort Lincoln Cemetery				24D. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 16 1965				25B. NAME OF REGISTRAR P. L. B. 2-1-65				25C. FUNERAL DIRECTOR Nalley's Funeral Home 3 Inc. 3			
ADDRESS Mt. Rainier Maryland											



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12783		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 12783	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOHN F. LESCHIEFSKY, SR.		2. DATE AND HOUR OF DEATH 12-13-65 5:26 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY -		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 18 MARYLAND GENERAL HOSPITAL		D. STREET ADDRESS (If rural, give location) 2006 Longview Court		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY Globe Brewing Co	
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 11-3-05	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John F. Leschiesky	
14. MOTHER'S MAIDEN NAME Margaret. (Unk)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-01-9359	
17. INFORMANT Patient on Admission		ADDRESS		18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinoma of lung (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH ? 1 yr.	
19. DATE OF OPERATION 12-7-65		20. AUTOPSY? (Yes or No) NO		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22. I certify that (1) (this hospital) attended the deceased from 11-3-65 to 12-13-65, that (1) (last saw the deceased alive on 12-13-65 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (1) (did) view the body after death.		23. SIGNATURE Francis A. Clark Jr.		23B. DATE SIGNED 12-13-65	
24. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/16/65		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park	
25A. DATE REC'D BY HEALTH DEPT. DEC 16 1965		25B. NAME OF REGISTRAR Wm. Cook-Brooks Inc.		25C. FUNERAL DIRECTOR 1217 St. Paul St. ADDRESS	



BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

JERRY GATEWOOD

2. DATE AND HOUR PRONOUNCED DEAD

12-12-65

8:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

FRANKLIN SQUARE HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2214 Cecil Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

March 3, 1900

9. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Landscaping

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Samuel Gatewood

14. MOTHER'S MAIDEN NAME

Henrietta Parsons

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

220-01-0224

17. INFORMANT

Mrs Edna Melvin 2214 Cecil Ave
Baltimore, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-13-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-16-65

23C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Park

23D. LOCATION

(City, town, or county)

(State)

Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.

DEC 16 1965

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Buller's Mortuary

ADDRESS

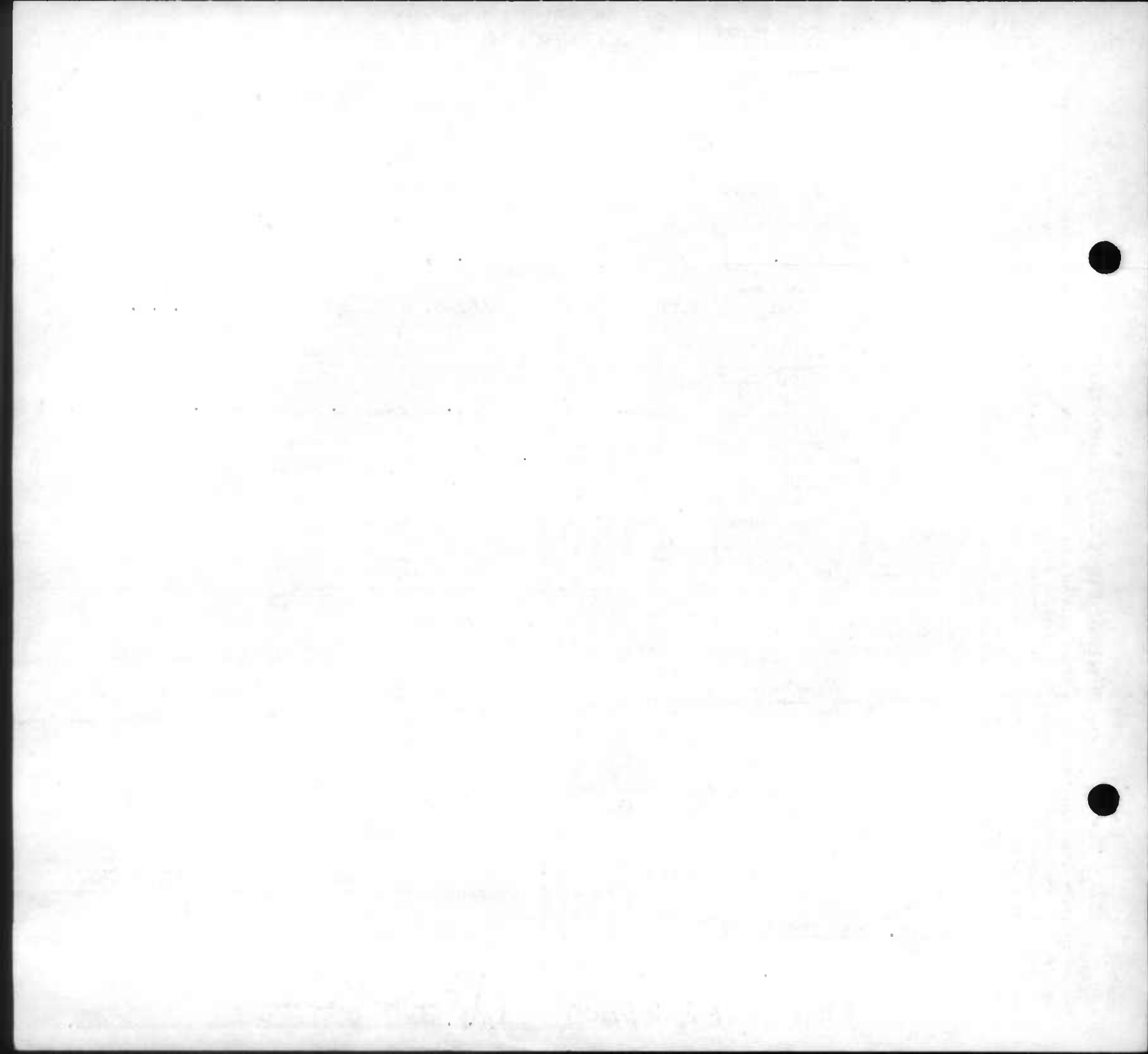
712 1/2 E. North Ave
Baltimore, Md 21202

WALTER
POLICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

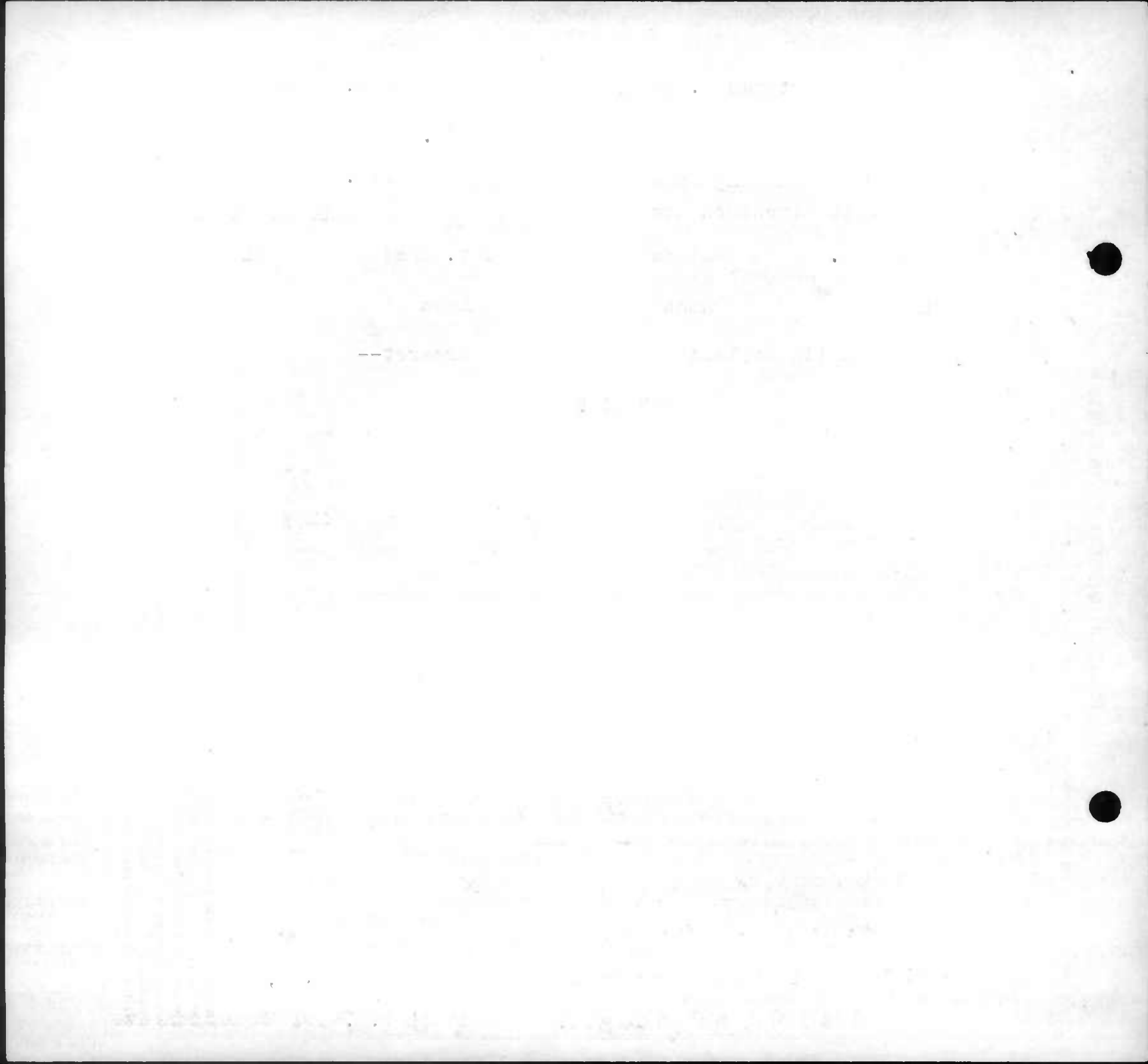
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12785	
BIRTH NO. 65 12785		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) LEONARD ZITO		DECEMBER 11, 1965 6 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL		A. STATE MARYLAND			
(If not in hospital or institution, give street address or location)		B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		D. STREET ADDRESS (If rural, give location)			
		2547 W. COLD SPRING LANE			
5. SEX MALE	6. RACE CAUC.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH SEP. 8, 1906	9. AGE (In years last birthday) 59	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FRUIT & PRODUCE		10B. KIND OF BUSINESS OR INDUSTRY FOOD INDUSTRY		11. BIRTHPLACE (State or foreign country) TORRAS, LOUISIANA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME SALVATORE ZITO			
14. MOTHER'S MAIDEN NAME MARIA FIDDUCLIA		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 216 01 6866		17. INFORMANT MRS. THERESA M. ZITO 2547 W. COLD SPRING LANE			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.141260X (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Diabetes Mellitus					
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		22A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov. 1, 1960 to Nov. 9, 1965, that (I) (we) last saw the deceased alive on Nov. 9, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sebastian Russo		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-13-65	
23C. PHYSICIAN'S NAME (Type) DR. SEBASTIAN RUSSO		23D. ADDRESS 5017 HARFORD ROAD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE DEC. 14, 1965		24C. NAME of CEMETERY or CREMATORY NEW CATHEDRAL CEMETERY	
24D. LOCATION BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. DEC 16 1965			
25B. NAME OF REGISTRAR J. E. J. J. J.		25C. FUNERAL DIRECTOR J. E. J. J. J.			
25D. ADDRESS 4611 PARK HEIGHTS AVE.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12786		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12786	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Gertrude F. Essex		2. DATE AND HOUR OF DEATH Dec. 13/65 10:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hoods Nursing Home 5313 Edmondson Ave		A. STATE Md. B. COUNTY 28-04			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto.			
		D. STREET ADDRESS (If rural, give location) 414 Athol Ave			
5. SEX Female	6. RACE W.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Oct. 2/84	9. AGE (In years last birthday) 81	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Canada	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Franklin Holland			14. MOTHER'S MAIDEN NAME Margaret--		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 217 05 8702		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Crown artery occlusion DUE TO (B) Arteriosclerotic Cardio Vasc. DUE TO dissection (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 26 19 53 to Dec 13 19 65 , that (I) (we) last saw the deceased alive on Dec 13 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Harry L. Knipp		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-15-65	
23C. PHYSICIAN'S NAME (Type) HARRY L. KNIPP		23D. ADDRESS 4116 Edmondson Ave Balto. 7, Md			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 12/16/65		24C. NAME OF CEMETERY or CREMATORY Woodlawn	
24D. LOCATION (City, town, or county) (State) Balto. 7, Md					
25A. DATE REC'D BY HEALTH DEPT. DEC 16 1965		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS Witzke F.D. 74101 Edmondson Ave	



1

65 12787

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12787

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

BELL C. MISSELL (NEE) MORRISON

2. DATE AND HOUR PRONOUNCED DEAD

Dec. 10, 1965

9:52 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Essex

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore - Essex

D. STREET ADDRESS (If rural, give location)

2103 Redthorn Rd.

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

5-14-1882

9. AGE (In years last birthday)

83

If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

MILLARD FILMORE MORRISON

14. MOTHER'S MAIDEN NAME

ALICE O'DELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

—

17. INFORMANT

ADDRESS

Norman Hillenburg, 2103 Redthorn Rd. #20

18.

E900.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) ~~Stroke~~ Bronchopneumonia complicating cranio-cerebral injury.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C).....

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

11, 3, 1965

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Intracranial exploration

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

2103 Redthorn Rd., Baltimore-Essex, Md.

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

November 3, 65 4:30 P.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell from stairs

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Dec. 11, 1965

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

12/14/65

23C. NAME OF CEMETERY or CREMATORY

Oak Lawn Cemetery

23D. LOCATION (City, town, or county) (State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 16 1965

24B. NAME OF REGISTRAR

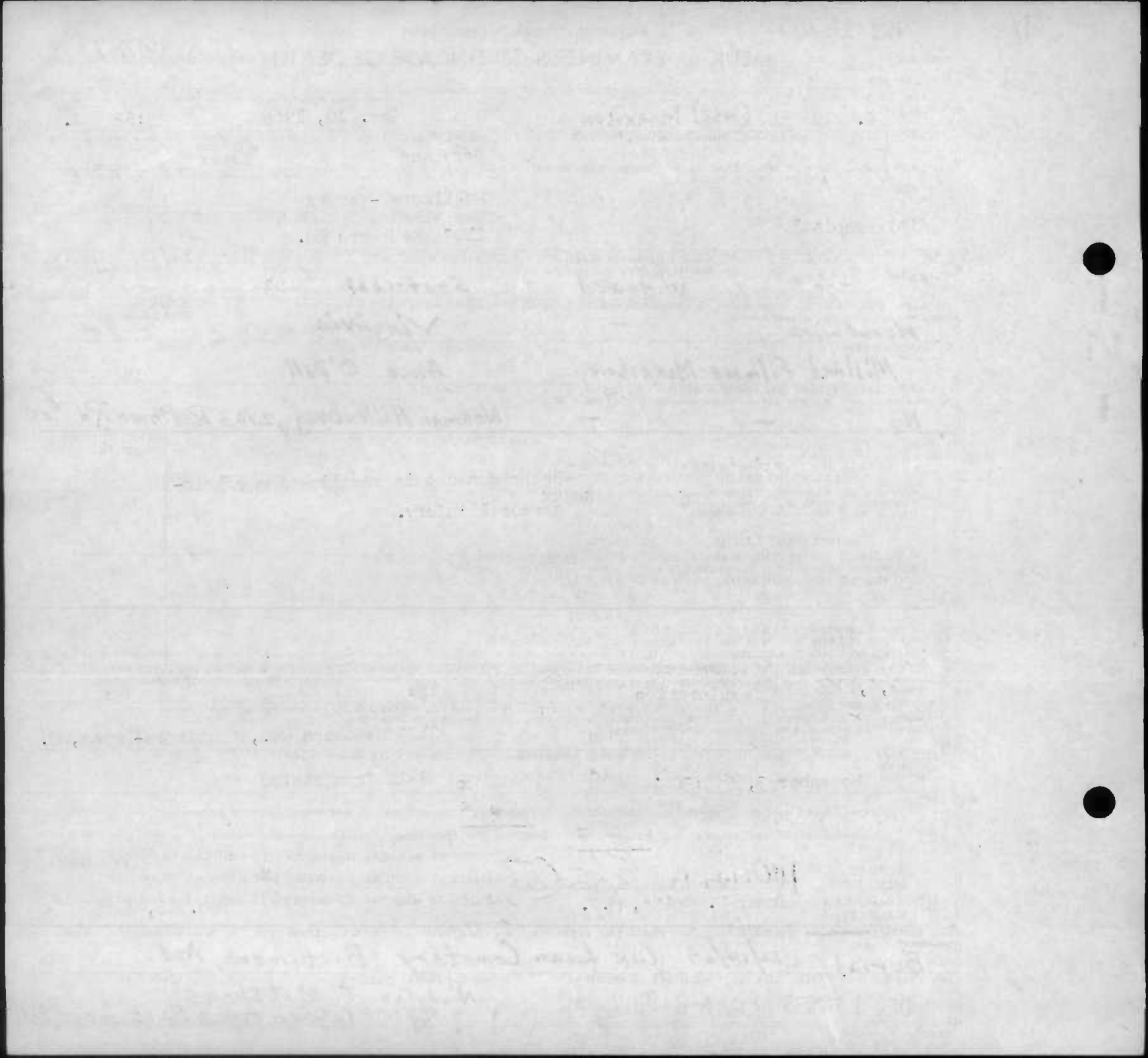
Robert E. Johnson

24C. FUNERAL DIRECTOR

Nicholas T. Matthews

ADDRESS

3031 Eastern Ave., Baltimore, Md.



CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

65 12788

65 12788

65 12788

2. DATE AND HOUR OF DEATH

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

D. STREET ADDRESS

(If rural, give location)

5. SEX

6. RACE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Yr.
Months: DaysIf Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 773.51

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Resp arrest
DUE TO

12 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B) immaturity
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notly medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At
Work ☐Not While
At Work ☐22. I certify that (I) (this hospital) attended the deceased from 12/14 1965 to 12/14 1965.
that (I) (we) last saw the deceased alive on 12-14-1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys. ☐Med.
Director ☐Stoll
Phys. ☒

23B. DATE SIGNED

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

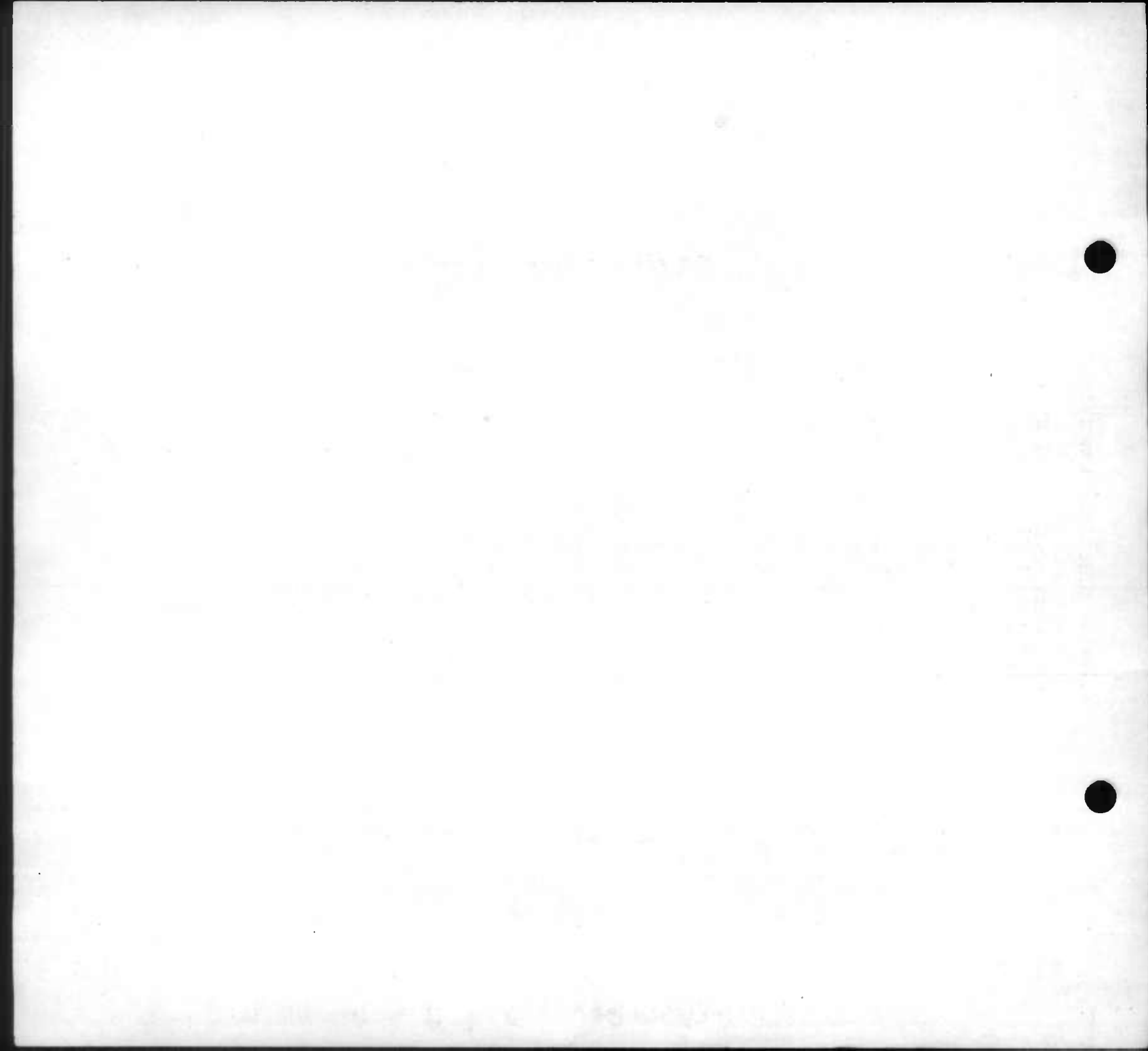
25C. FUNERAL DIRECTOR

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

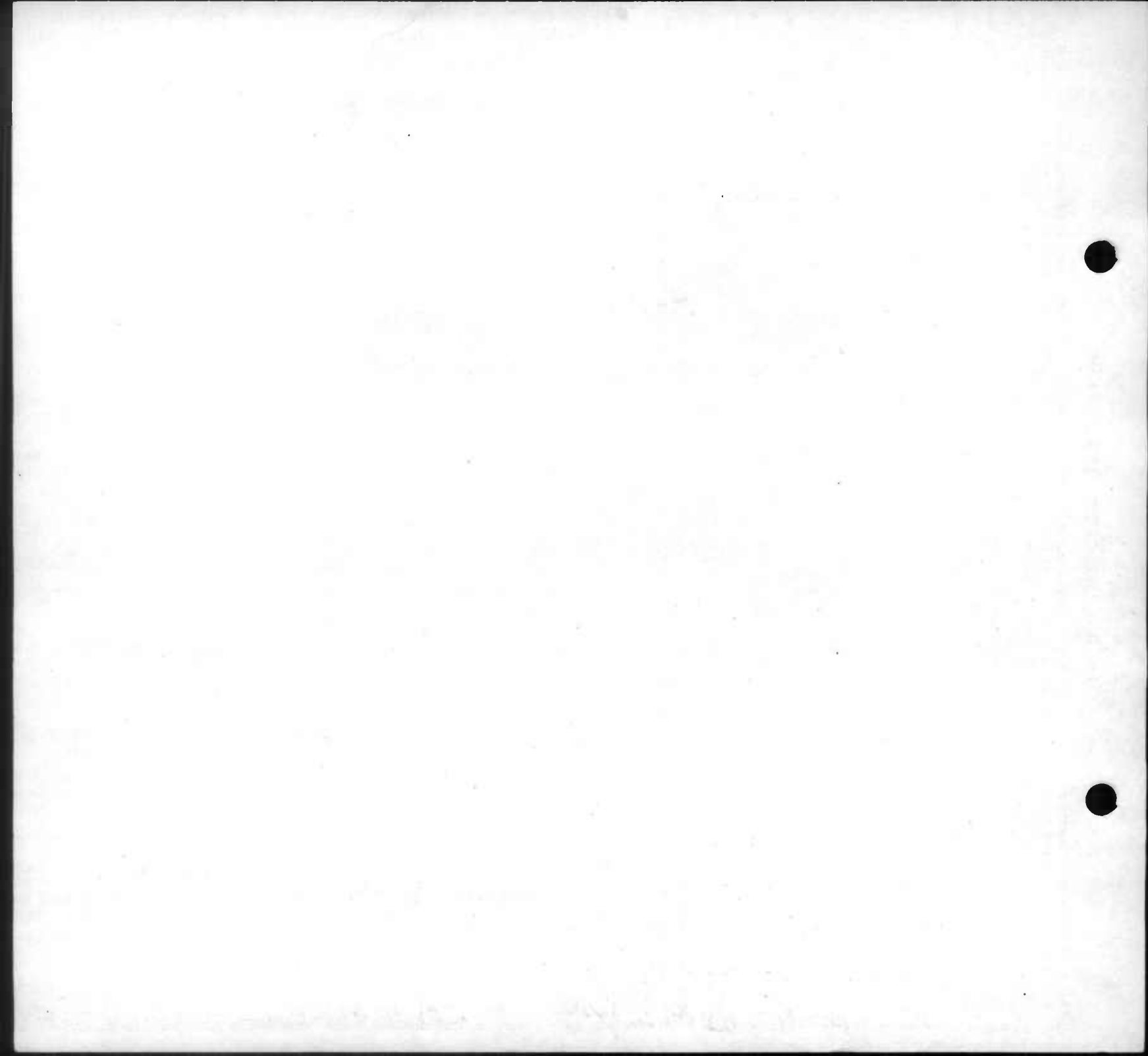
BABY GIRL
WILLIAMS
 CREMATION 12-15-65 JOHNS HOPKINS HOSPITAL BALTIMORE 6. MD
 DEC 16 1965 P. 11 11 HOSPITAL DISPOSAL



FUNERAL DIRECTOR: IMPORTANT

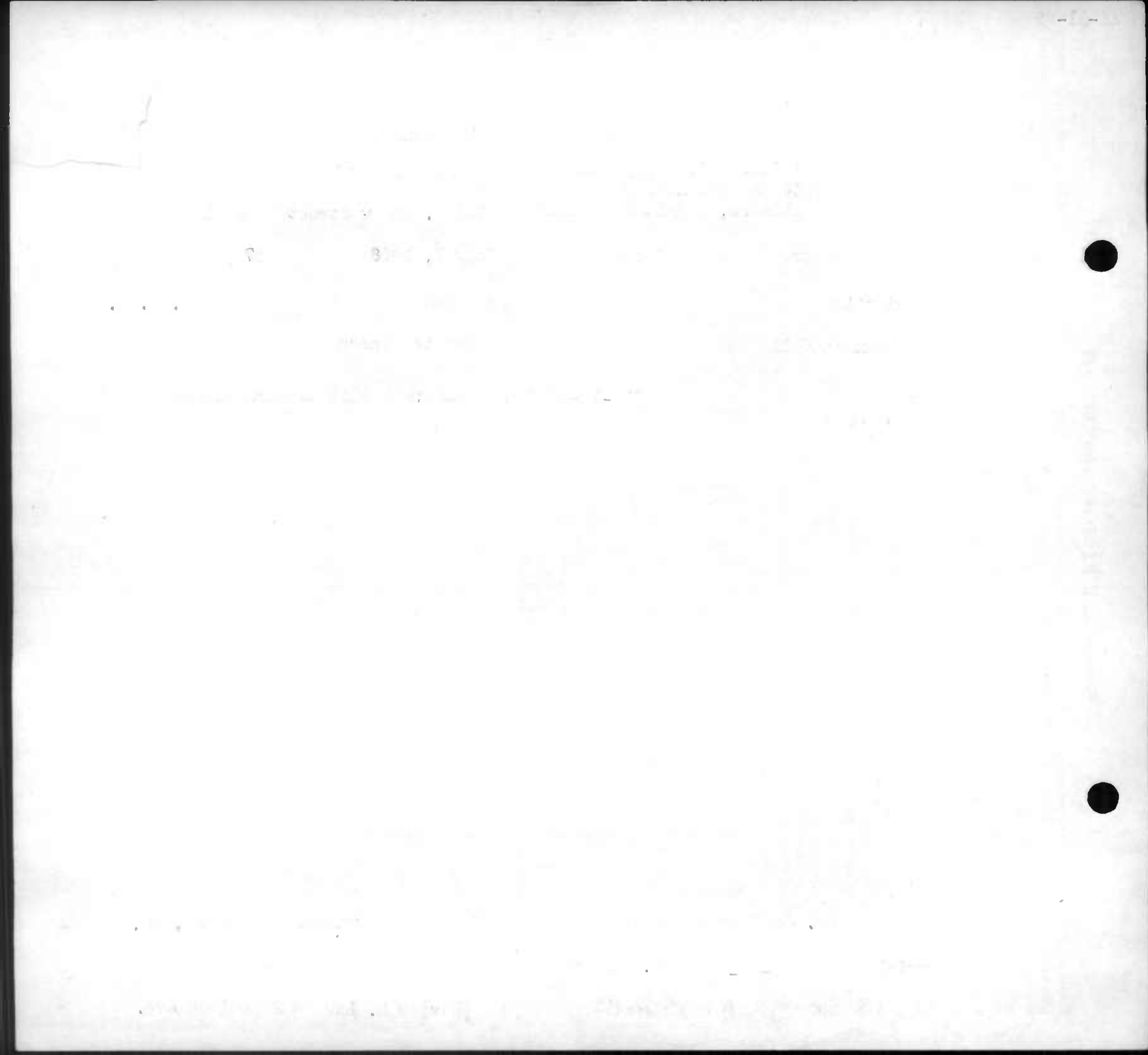
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12789	
BIRTH NO. 65 12789		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Robert Funn		Dec 13, 1965 10:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 1000 W. Lexington ST.		A. STATE Maryland B. COUNTY 18-02	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 1000 W. Lexington ST.	
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH
			9. AGE (In years last birthday) 62
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Richmond, VA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 490X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Label Pneumonia		CAUSE OF DEATH Label Pneumonia	
INTERVAL BETWEEN ONSET AND DEATH 5 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec 13 1965 to 19 , that (I) was last saw the deceased alive on Dec 13 1965 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) did not view the body after death.			
23A. SIGNATURE William H. Watts		23B. DATE SIGNED 12-16-65	
23C. PHYSICIAN'S NAME (Type) William H. Watts		23D. ADDRESS 515 N. Lexington St. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-17-65	
24C. NAME OF CEMETERY or CREMATORY MT. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 16 1965		25B. NAME OF REGISTRAR Robert Funn	
25C. FUNERAL DIRECTOR Robert Funn		25D. ADDRESS 1000 B. Thayer Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

44-31-85		65 12790		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12790	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <i>Dorothy S. Dixon S.</i>				2. DATE AND HOUR OF DEATH <i>12-13-65 3 45 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</i>				A. STATE <i>Maryland</i> B. COUNTY <i>17-01</i>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
				D. STREET ADDRESS (If rural, give location) <i>526 N. Eutaw Street 21201</i>			
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>		8. DATE OF BIRTH <i>July 7, 1908</i>	9. AGE (In years last birthday) <i>57</i>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>William Randall</i>				12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>212-14-9808</i>		17. INFORMANT ADDRESS <i>RECORDS: BCH 4940 Eastern Avenue 21224</i>	
18. <i>170 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of the breast.</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <i>29 years.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>8-10</i> 19 <i>65</i> to <i>12-13</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>12-13</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Jeffrey P. Aaronson</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>12-13-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. Jeffrey Aaronson</i>				23D. ADDRESS M.D. <i>4940 Eastern Avenue Baltimore, Md. 21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-17-65</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. Auburn</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 16 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Charles R. Law</i>		ADDRESS <i>802 Madison Ave.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12791	
BIRTH NO. 65 12791		M.E. CASE NO. 65 12791		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Hodge Richard NMN</u>			2. DATE AND HOUR OF DEATH <u>12-15 '65</u> <u>11. 20 A.M.</u>		
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>9-07</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>The Union Memorial Hospital</u>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		
			D. STREET ADDRESS (If rural, give location) <u>1611 CARSWELL ST.</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>9-21-1882</u>	9. AGE (In years last birthday) <u>83</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired.</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>
13. FATHER'S NAME <u>unknown</u>			14. MOTHER'S MAIDEN NAME <u>Annie Hodge</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>Mrs. Madeline McCallum 1611 Carswell St</u>		
18. <u>491X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>broncho pneumonia</u> <u>bilateral.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>N</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-13</u> 19 <u>65</u> to <u>12-15</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>11. 20 AM 12-15-19 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Pyoung IL KWON</u> M.D.				23B. DATE SIGNED <u>12-15 '65</u>	
23C. PHYSICIAN'S NAME (Type) <u>PYOUNG IL KWON</u>				23D. ADDRESS <u>The Union Memorial Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-18-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Cherry Hill meth. Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>GRANITE, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 16 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>The Morton & Dyett Fun'l Home, 1701 Laurens</u>	

10/10/10

10/10/10

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PICOLE FULLIARD

2. DATE AND HOUR PRONOUNCED DEAD

12-13-65

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1429 HARFORD AVENUE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1429 Harford Avenue

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

5/5/38

9. AGE (In years
last birthday)

27

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Winston Salem N C

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

John McKnight

14. MOTHER'S MAIDEN NAME

Minnie

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Connie Bowser

18. 491X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Bronchopneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Extensive fatty infiltration of liver

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-13-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/16/65

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

(State)

A A County Md

24A. DATE REC'D BY HEALTH DEPT.

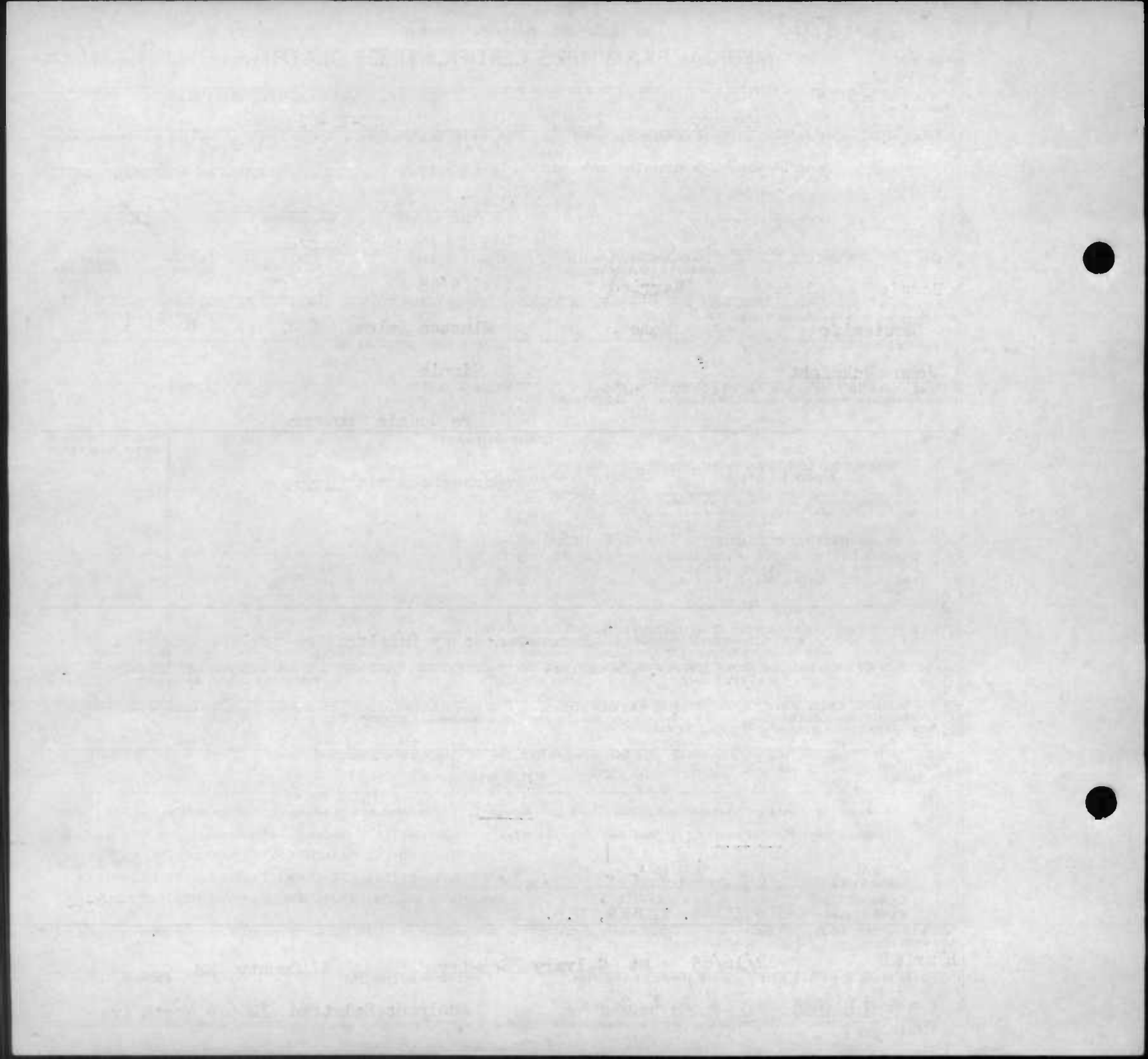
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 16 1965

Adolphus Halstead 1206 W North Ave

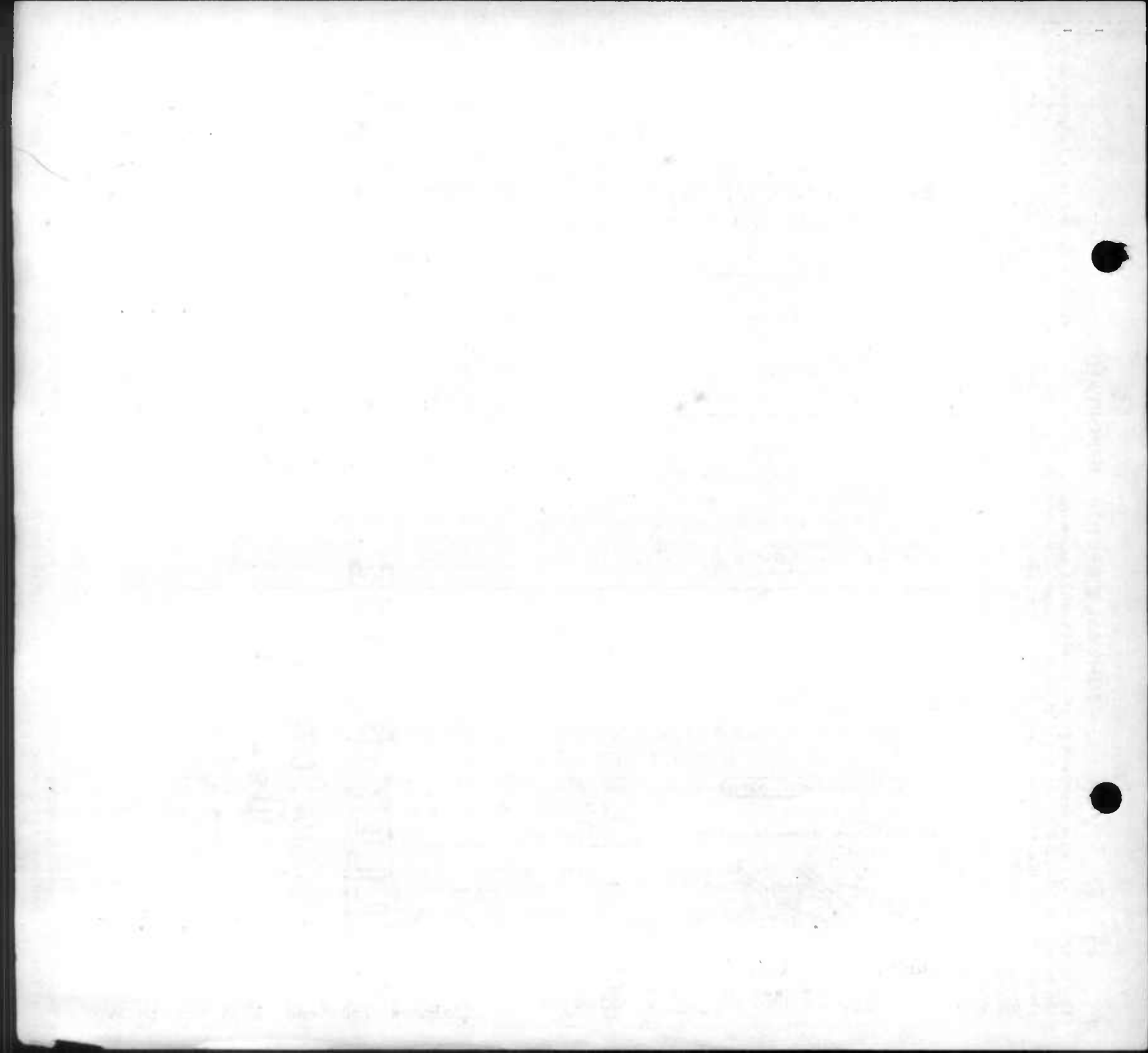


44-11-58

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12793		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 12793	
1. NAME OF DECEASED (Type or Print) William Kennedy			2. DATE AND HOUR OF DEATH 12-13-65 1 10 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4940 Eastern Avenue Baltimore City Hospital Baltimore, Maryland 21224			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 1100 Ashland Court B. COUNTY Baltimore, Md. 21202 C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) 10-87		
5. SEX MALE	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 2-29-84	9. AGE (In years last birthday) 81	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME William			14. MOTHER'S MAIDEN NAME Ardelia		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224		
18. 332 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral thrombosis			INTERVAL BETWEEN ONSET AND DEATH 24 hours		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diffuse severe cerebral arteriosclerosis					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertensive Cardiovascular disease					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-10-1965 to 12-13-1965 , that (I) (we) lost saw the deceased alive on 12-13-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jeffrey J. Aaronson			23B. DATE SIGNED 12-13-65		
23C. PHYSICIAN'S NAME (Type) Dr. Jeffrey Aaronson			23D. ADDRESS 4940 Eastern Avenue Baltimore, Md. 21224		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/18/65	24C. NAME OF CEMETERY or CREMATORY Arbutus Mem Park	24D. LOCATION (City, town, or county) (State) Baltimore Md		
25A. DATE REC'D BY HEALTH DEPT. DEC 16 1965		25B. NAME OF REGISTRAR Adolphus Halstead	25C. FUNERAL DIRECTOR ADDRESS 1206 W North Ave		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>65 12794</u>	
BIRTH NO. <u>65 12794</u>				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <u>SARAH MYERS</u>				2. DATE AND HOUR OF DEATH <u>13 DECEMBER 1965</u> <u>8:00 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>38 UNIVERSITY HOSPITAL</u>				A. STATE <u>MARYLAND</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
				D. STREET ADDRESS (If rural, give location) <u>946 BENNETT PLACE</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>12 Feb. 10</u>	9. AGE (In years last birthday) <u>55</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>JAMES GARRISON</u>			14. MOTHER'S MAIDEN NAME <u>IDA</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ador Myers 2910 Grantly Ave</u>		
18. <u>331X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>CHRONIC VASCULAR DISEASE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>CHRONIC VASCULAR DISEASE</u> DUE TO <u>ACCIDENT</u> (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12 DECEMBER 1965</u> to <u>13 DECEMBER 1965</u> , that (I) (we) lost saw the deceased alive on <u>13 DECEMBER 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Donald M. Barrick</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>13 DECEMBER 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>Donald M. Barrick</u>				23D. ADDRESS M.D. <u>88 UNIVERSITY HOSPITAL - BALTO.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/18/1965</u>		24C. NAME OF CEMETERY OR CREMATORY <u>W. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 16 1965</u>		25B. NAME OF REGISTRAR <u>R. E. F. F.</u>		25C. FUNERAL DIRECTOR <u>Williams Funeral Home</u>		ADDRESS <u>319 N. Schroeder St</u>	

1
B-624

65 12795 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12795

BIRTH NO. M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) PAULINE BROCKWELL		2. DATE AND HOUR PRONOUNCED DEAD Dec. 10, 1965 10:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) City Morgue, 700 Fleet Street, Balto.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2832 Guilford Ave.	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 7, 1920
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 45
13. FATHER'S NAME Jesse O. Rice		14. MOTHER'S MAIDEN NAME Martha Edwards	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 246-22-7574	17. INFORMANT ADDRESS Mrs. Marie S. Barton 3706 Reisterstown Rd.
18. 330X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Massive subarachnoid and intraventricular hemorrhage of brain originating from circle of Willis.		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED Dec. 11, 1965	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial	23B. DATE Dec. 16, 1965	23C. NAME of CEMETERY or CREMATORY Loudon Park	23D. LOCATION (City, town, or county) (State) Baltimore Md.
24A. DATE REC'D BY HEALTH DEPT. DEC 16 1965	24B. NAME OF REGISTRAR Robert E. Spitz, M.D.	24C. FUNERAL DIRECTOR ADDRESS Wm. A. Pickens & Sons N. & P. H. Aves.	

VS 151-REV. 1/1/65

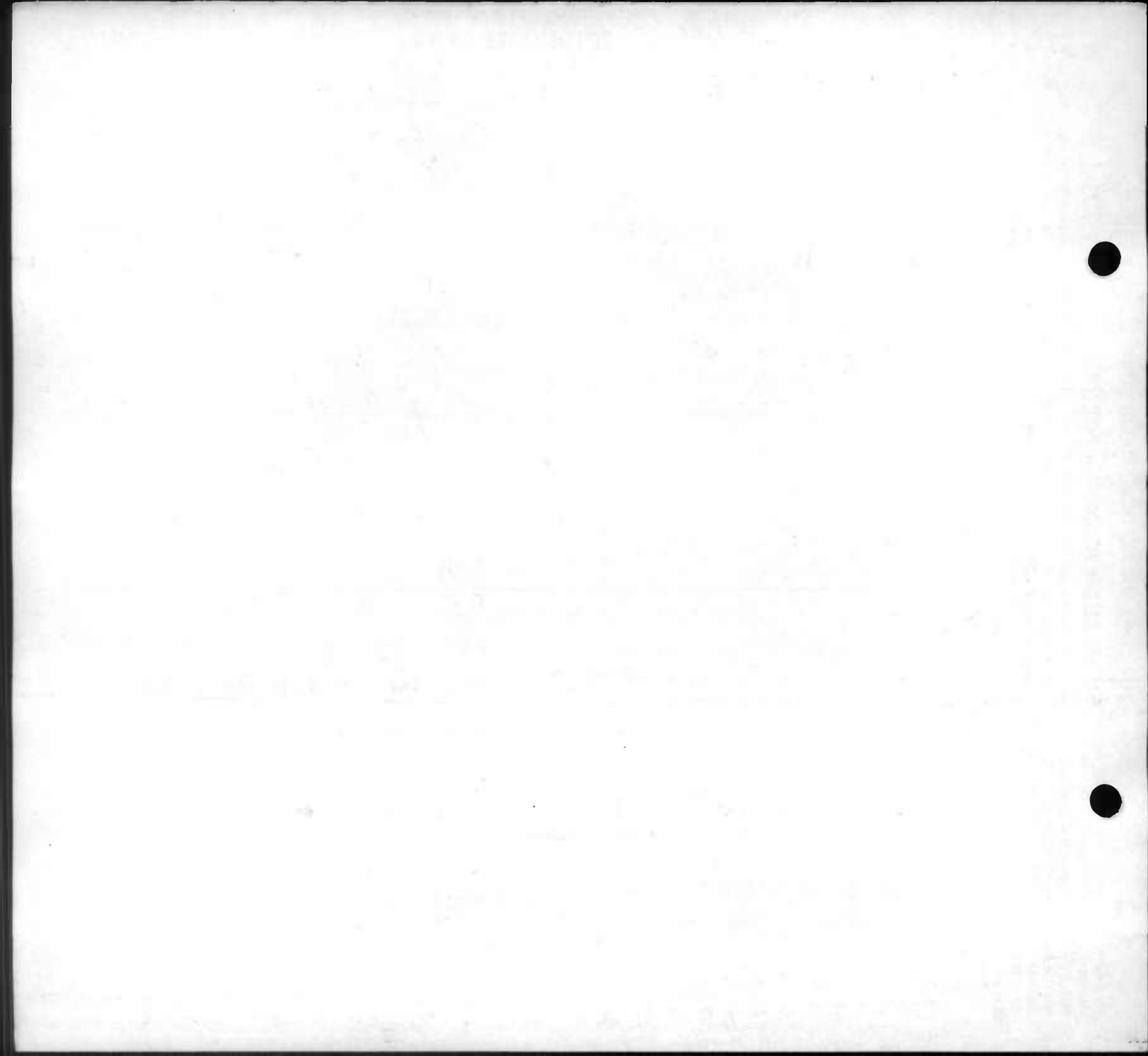
VALLEY
FORD
FORD

Wm. H. Ford

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No.	
65 12796						65 12796	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Clyde E. Stivers				12/11/65 9:10 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY 2504	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 4221 Thayer Ct. #25			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3/13/07	9. AGE (In years last birthday) 58	11. Under 1 Yr. Months: Days: Hours: Min.		12. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10B. KIND OF BUSINESS OR INDUSTRY B&O Railroad		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Godfrey W. Stivers				14. MOTHER'S MAIDEN NAME Mary Shipley			
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 705-05-7979		17. INFORMANT Mary Stivers		ADDRESS 4221 Thayer Ct. #25	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) pseudomonas septicemia Multiple intraabdominal abscesses				INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 11/22/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Zollinger Ellison Syndrome		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from Nov. 11 1965 to Dec. 11 1965 , that (we) last saw the deceased alive on Dec. 11 1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) the body after death.							
23A. SIGNATURE Bruce H. MacPherson				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/11/65	
23C. PHYSICIAN'S NAME (Type) Bruce H. MacPherson				23D. ADDRESS 7036 McLEAN BLVD. BALTO., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/15/65		24C. NAME OF CEMETERY or CREMATOR Glen Haven Memorial Park		24D. LOCATION (City, town, or county) (State) Anne Arundel, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 16 1965		25B. NAME OF REGISTRAR Charles Stevens		25C. FUNERAL DIRECTOR Charles Stevens Funeral Home, Inc.			
				ADDRESS 4180 E. Fort Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

65 12797		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12797	
BIRTH NO.		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print)		6 05 am 12-12-65 M.			
Mannion Lawrence Asa		7903			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Union Mem. Hosp.		Maryland			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore			
D. STREET ADDRESS (If rural, give location)		726 W. Keweenaw Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days Hours Min.
Male	White	Widowed	8-12-92	73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Salesman				Baltimore, Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John Mannion			Bridget Monahan		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		216-09-9112		Lawrence A. Mannion, Jr. 3832 Monterey Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
331X1		Circulatory Collapse 2 hours.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) CVA., myocardial infarct. 6 days			
		(C) arteriosclerosis ?			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Removal of iliac embolization.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
12-10-65		Ilio-femoral emb.		—	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-6 1965 to 12-12 1965, that (I) (we) last saw the deceased alive on 12-11 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE			
Albert Montague		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-12-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
MONTAGUE		Med. Arts Bldg.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATOR	
Burial		12/15/65		New Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State)		Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 16 1965		Robert E. Johnson		Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue.	

Planned on tomorrow 10-10-10

Newman Farm No. 6

10-10-10 10-10-10

10-10-10 10-10-10

10-10-10 10-10-10

10-10-10 10-10-10

10-10-10 10-10-10

Cincinnati College 10-10-10

CMA - 10-10-10 10-10-10

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10-10-10 10-10-10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 12798</u>	
65 12798				CERTIFICATE OF DEATH	
BIRTH NO.				DATE AND HOUR OF DEATH	
M.E. CASE NO.				12 - 13 - 65 9 A. M.	
1. NAME OF DECEASED (Type or Print) <u>Martin J. Kroat</u>				2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>South Baltimore General Hospital</u>				A. STATE <u>Maryland</u>	
				B. COUNTY <u>2401</u>	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>				D. STREET ADDRESS (If rural, give location) <u>1330 E. Fort Avenue</u>	
5. SEX <u>m</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>3/23/02</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months Days : If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Independent Ice</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John Kroat</u>	
14. MOTHER'S MAIDEN NAME <u>Dora Wright</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>214-03-3943</u>				17. INFORMANT ADDRESS <u>Mrs. Pauline Kroat 1330 E. Fort Ave.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>179.0 I Carcinoma of Penis (circumcised)</u>				INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1961</u> to <u>12-13-65</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12-6-65</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Morris B. Schreiber</u>				23B. DATE SIGNED <u>12-15-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>MORRIS B. SCHREIBER</u>				23D. ADDRESS <u>1519 W. Lombard St.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/16/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Like View Memorial Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Carroll, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 16 1965</u>			
25B. NAME OF REGISTRAR <u>John J. ...</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Charles E. Stevens Funeral Home, Inc. 1401 E. Fort Ave.</u>			

1900

1900

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65 12799

BALTIMORE CITY HEALTH DEPARTMENT

65 12799

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LEO CURRAN

2. DATE AND HOUR PRONOUNCED DEAD

12. 10. 65

10.45 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE ~~MASSACHUSETTS~~ MASS.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Somerville,

D. STREET ADDRESS (If rural, give location)

#7, Dane Ave

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

13 MAY 1944

9. AGE (In years
last birthday)

21

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MARINE U.S.M.C.

10B. KIND OF BUSINESS OR INDUSTRY

U. S. GOV't

11. BIRTHPLACE (State or foreign country)

MASS

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

LEO CURRAN

14. MOTHER'S MAIDEN NAME

Mary Keamey (DECEASED)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

16. SOCIAL
SECURITY NO.

025-32-2811

17. INFORMANT

Curran Sr. same as #4

ADDRESS

18.

E 812.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

WHIPLASH INJURY with Fracture of

base of skull

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

U.S. Route #1, South of Savage light

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)
12 10 65 10.15 pm

21E. INJURY OCCURRED

WHILE AT
WORK

NOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

struck by car while walking

63-00

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12. 11. 65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

16, Dec. 1965

23C. NAME of CEMETERY or CREMATORY

HOLY CROSS CEMETERY

23D. LOCATION

(City, town, or county)

(State)

MALDEN, MASS.

24A. DATE REC'D BY HEALTH DEPT.

DEC 16 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Harold S. Wade, 550 Wash. Blvd., Laurel, Md.

ADDRESS

MR-12

3 MAY 1944

(DECEASED)

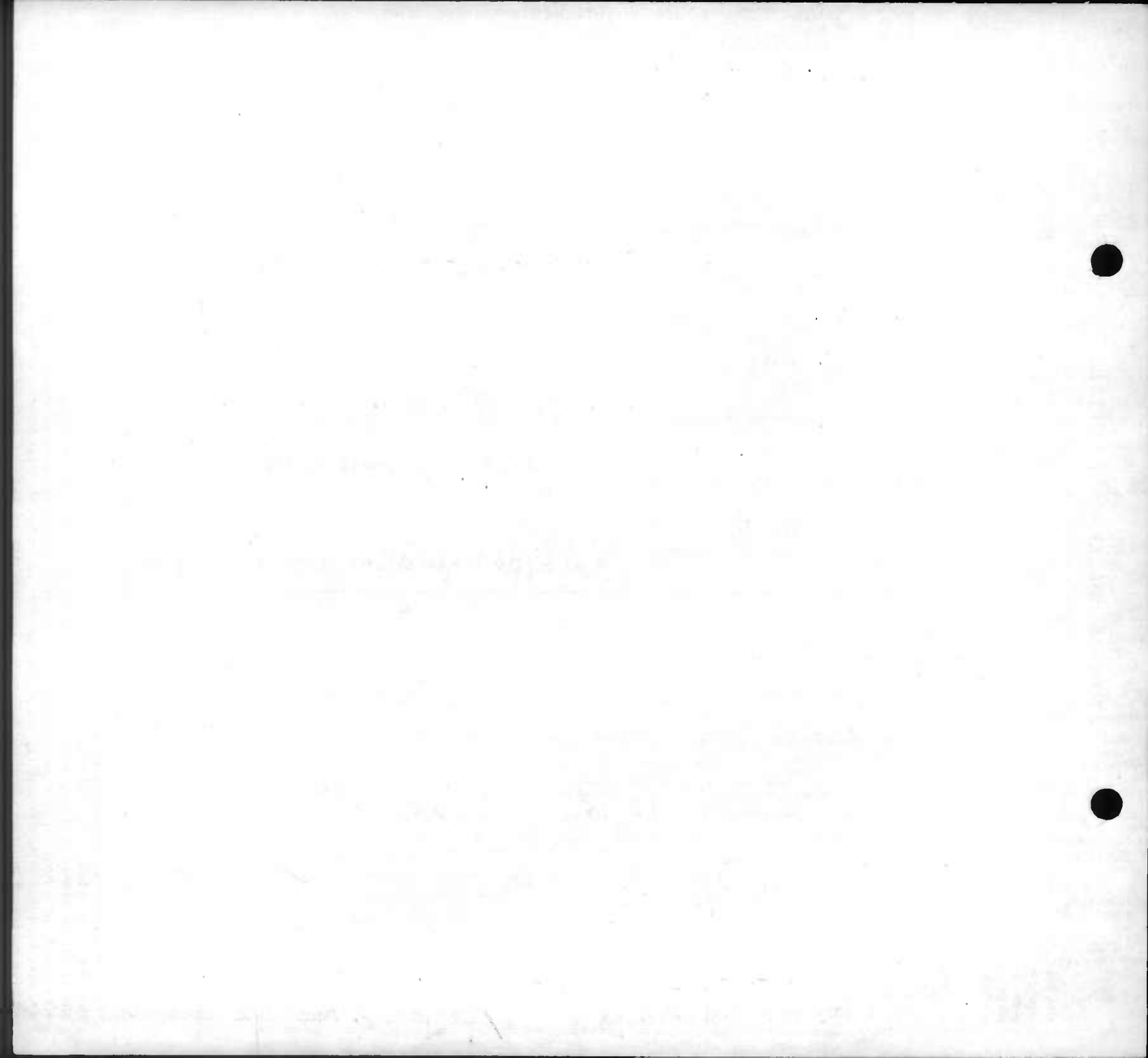
622-12-1211

[Handwritten signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 12800	
BIRTH NO. 65 12800		M.E. CASE NO. 65 12800		1. NAME OF DECEASED MARGARET E. SEIBERT		2. DATE AND HOUR OF DEATH 12-15-65 5:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital				A. STATE Md. B. COUNTY 27-38			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 14			
				D. STREET ADDRESS (If rural, give location) 5729 Edgepark Road			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 4-9-1901	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Clerk		10B. KIND OF BUSINESS OR INDUSTRY Divorced		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William J. Tarr				14. MOTHER'S MAIDEN NAME Elizabeth Smith			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216013119		17. INFORMANT William A. Seibert, Jr.		ADDRESS same	
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				(A) ARTERIOSCLEROTIC HEART DISEASE		CHRONIC	
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Hypothyroidism, compensated		years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12-11-1965 to 12-15-1965 that (I) (we) last saw the deceased alive on 12-15-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. David Angel				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-16-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 12-18-65		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 16 1965		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc		ADDRESS Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																									
BIRTH NO. 65 12801					CERTIFICATE OF DEATH					Registered No. 65 12801															
1. NAME OF DECEASED (Type or Print) <i>Emma Jane Stone</i>					2. DATE AND HOUR OF DEATH <i>12-16-65</i> <i>1 45</i> <i>4</i> M.																				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>26-01</i>																				
FULL NAME OF HOSPITAL OR INSTITUTION <i>House In the Pines-Belair Road</i>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore # 6</i>																				
					D. STREET ADDRESS (If rural, give location) <i>5520 Summerfield Ave.</i>																				
5. SEX <i>female</i>		6. RACE <i>white</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>		8. DATE OF BIRTH <i>6-19-1895</i>		9. AGE (In years last birthday) <i>70</i>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.													
10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <i>Maryland</i>					12. CITIZEN OF WHAT COUNTRY? <i>USA</i>										
13. FATHER'S NAME <i>Aaron Schaffer</i>					14. MOTHER'S MAIDEN NAME <i>Louise Bankert</i>																				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <i>219163090</i>					17. INFORMANT <i>Howard F. Stone</i>					ADDRESS <i>same</i>										
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>18. <i>356.1 I</i></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.</p> </div> <div style="width: 45%;"> <p>CAUSE OF DEATH</p> <p>(A) <i>Amyotrophic lateral sclerosis</i></p> <p>DUE TO</p> <p>(B) _____</p> <p>DUE TO</p> <p>(C) _____</p> </div> </div>										INTERVAL BETWEEN ONSET AND DEATH <i>4 years</i>															
										<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>															
										19A. DATE OF OPERATION <i>0</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
										21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?																	
<p>22. I certify that (I) (this hospital) attended the deceased from <i>1964</i> to <i>Dec. 16, 1965</i>, that (I) we lost saw the deceased alive on <i>December 14, 1965</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) we (did) did not view the body after death.</p>																									
23A. SIGNATURE <i>Donald J. Jancoff</i> M.D.										Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED											
23C. PHYSICIAN'S NAME (Type) <i>R. Donald Jancoff</i>										23D. ADDRESS <i>M.D.</i>															
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>12-20-65</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Krider's Cemetery</i>				24D. LOCATION (City, town, or county) (State) <i>Westminster, Maryland Md.</i>																	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 16 1965</i>				25B. NAME OF REGISTRAR <i>Robert E. Jancoff</i>				25C. FUNERAL DIRECTOR <i>Leopold G. Buck Inc Baltimore, Md.</i>				ADDRESS													

From the [illegible] [illegible]

Yours truly
[illegible signature]

FOR APPROVAL OF THE MEDICAL EXAMINER
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 12802		65 12802		65 12802	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
STEVE MALLIS		12-15-65 5:30P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
ST AGNES HOSPITAL, WILKENS & CATON AVE BALTO 29, MARYLAND		MARYLAND		BALTIMORE	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE #13	
		D. STREET ADDRESS (If rural, give location)		2208 PELHAM AVE	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MALE	WHITE	WIDOWER	4-8-1897	72 74	RESTAURANT OWNER
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
RESTAURANT OWNER			GREECE	USA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
NICK MALLIS			MARY BELEGRISS Belegris		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			17. INFORMANT ADDRESS		
NO			WILKENS & CATON AVE BALTO #29 MD		
16. SOCIAL SECURITY NO.			ST AGNES HOSPITAL RECORDS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH		
422.1 I			ARTERIO SCLEROTIC CO. V. D.		
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
Dec. 15, 1965		Benign Prostatic Hyper.		No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from 12-10 1965 to 12-15 1965, that (X) (we) last saw the deceased alive on 12-15 1965 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Nicholas White, M.D.				Dec. 15, 1965	
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
NICHOLAS WHITE			St Agnes Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
burial		12-18-65		WOODLAWN Cemetery Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 16 1965		Robert E. [unclear]		Leonard & Ruck Inc Baltimore, Md.	

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

BIRTH NO.

65 12803

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 12803

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Catherine JACKSON

2. DATE AND HOUR PRONOUNCED DEAD

Dec. 12, 1965

11:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

700 Fleet Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

320 E. 20 1/2 Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Oct 10 - 1911

9. AGE (In years
last birthday)

54

10. Under 1 Yr. 11. Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George E Hall

14. MOTHER'S MAIDEN NAME

Josephine Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Catherine Kess 2023 Kennedy Ave

18.

E 983X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Subdural Hematoma
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.) home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

320 E. 20 1/2 Street

21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)

Dec. 11, 1965 6:30

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

allegedly beaten by husband

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Dec. 12, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-16-65

23C. NAME OF CEMETERY or CREMATORY

Mt Calvary Cem A.A. Co

23D. LOCATION

(City, town, or county)

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

DEC 16 1965

24B. NAME OF REGISTRAR

R. J. E. Jr. M.D.

24C. FUNERAL DIRECTOR

Rayner Sanders 217 E. Preston St

ADDRESS

WILLIAM POLICE

Oct 10-1911
Baltimore
George Hall
Cottman House

Wichita

George Hall

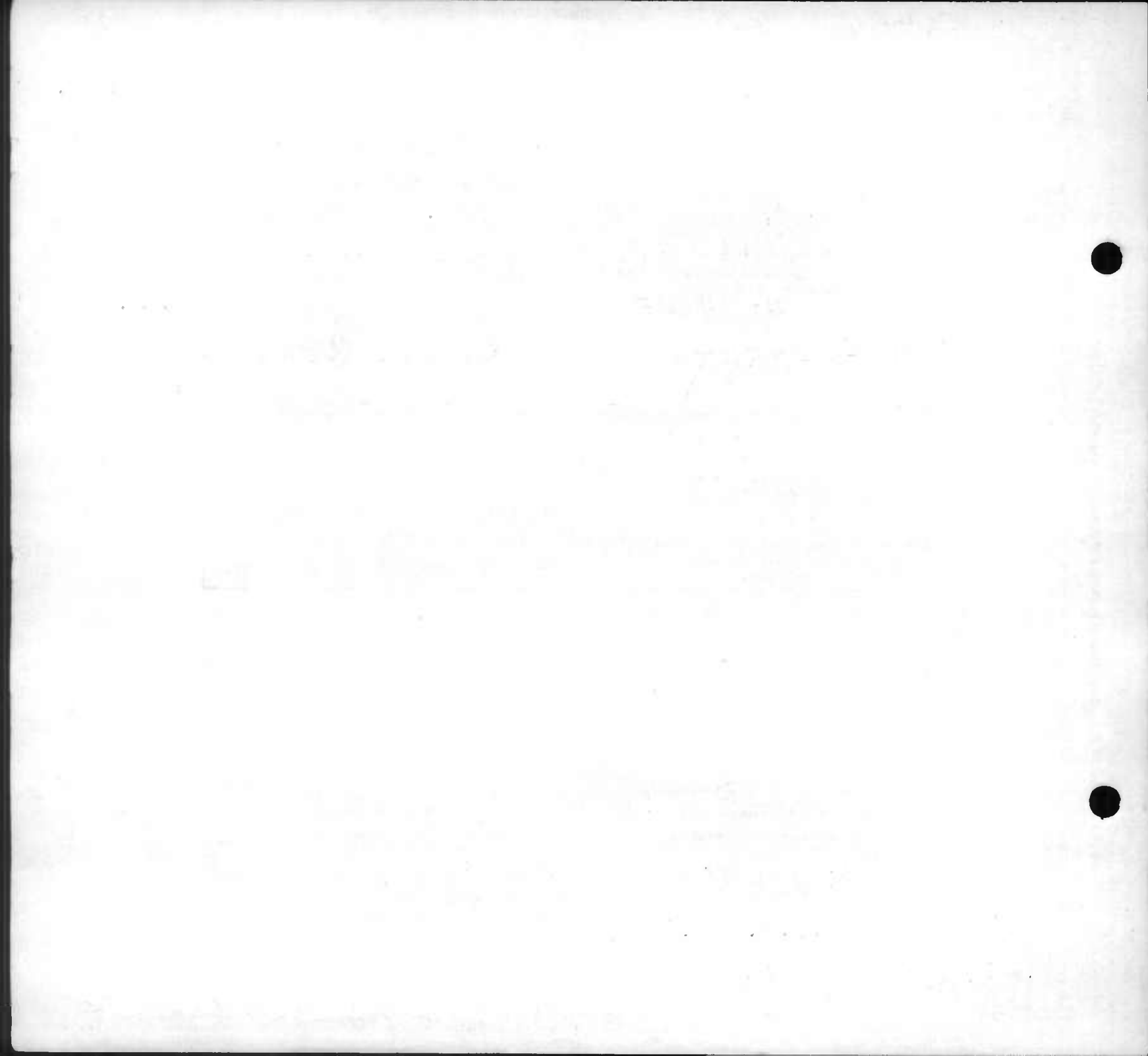
11.

Recd. 12-15-12 Mr. C. A. Co.

James S. S. S. S.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12804		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12804	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		GRACE W. GRANRUTH		12/14/65 7:30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 1940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		A. STATE MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	
8. DATE OF BIRTH 4-20-03		9. AGE (In years last birthday) 62		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WM. GRANRUTH	
14. MOTHER'S MAIDEN NAME RACHEL BERENGER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -	
17. INFORMANT BCH-RECORDS-4940 EASTERN AVENUE #21224		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CUA.		INTERVAL BETWEEN ONSET AND DEATH 1 day.	
19. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-13 19 65 to 12-14 19 65 , that (I) (we) last saw the deceased alive on 12-14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE K. R. Tucker		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) DR. K. R. TUCKER		23D. ADDRESS 4940 EASTERN AVENUE #21224		24. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 12/17/65		24C. NAME OF CEMETERY or CREMATORY MT. CARMEL		24D. LOCATION (City, town, or county) (State) Balta. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 16 1965		25B. NAME OF REGISTRAR DR. J. E. Sullivan		25C. FUNERAL DIRECTOR S. V. Hoffmann	
25D. ADDRESS 3218 Hudson St.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH									
BIRTH NO. <u>656 12805</u>		Registered No. <u>65 12805</u>							
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Mr John GRANRUTH</u>				2. DATE AND HOUR OF DEATH <u>DEC 15, 1965</u> <u>112 30</u> <u>A</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>37 Mercy Hospital, Inc.</u>					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>26-07</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>21224</u> D. STREET ADDRESS (If rural, give location) <u>310 S. MACON ST.</u>				
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>11/13/06</u>	9. AGE (In years last birthday) <u>59</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed AMER. STAN. RADIATOR</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>BALTIMORE, MD</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William G. GRANRUTH</u>			14. MOTHER'S MAIDEN NAME <u>Rachel BANNER</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unk No.</u>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>614 S. MACON ST.</u> <u>MRS. JOSEPHINE GRANRUTH</u>				
18. <u>587.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>Pseudomonas Pneumonia</u> DUE TO <u>confluent pul. edema</u> (B) <u>Peritonitis</u> DUE TO <u>3 days.</u> (C) <u>Pancreatitis</u> <u>unk</u>			INTERVAL BETWEEN ONSET AND DEATH <u>One week</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>11/29/65, 12/8/65</u> <u>12/13/65</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>ULCER, GANGRENE BOWEL ETC</u>			20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from <u>Nov 17</u> 19 <u>65</u> to <u>DEC. 15</u> 19 <u>65</u> , that (H) (we) last saw the deceased alive on <u>DEC 15</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Wm Gregory Bruce</u>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12/15/65</u>	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/18/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>SACRED HEART</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. Co. MD.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 16 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Smith, M.D.</u>		25C. FUNERAL DIRECTOR <u>G. K. Hoffmann</u>		ADDRESS <u>3218 HUDSON ST.</u>			

at 2.45
1000 ft - 1000 ft
the mountain range
is very high
at 2.45

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. K 452 65 12806		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12806	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Klingelhofer, Anna		2. DATE AND HOUR OF DEATH 12/14/65 10:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 26-36			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 1132 Dundalk Avenue 21224			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOW	8. DATE OF BIRTH 5-10-1898	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Louis BLEI		14. MOTHER'S MAIDEN NAME AUGUSTA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.11		CAUSE OF DEATH (A) Respiratory arrest (B) Cor Myocardial infarction (C) Obesity ? pulmonary emboli		INTERVAL BETWEEN ONSET AND DEATH 10 min 2 hrs, 2 d.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. tracheostomy		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 3/12/5		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Resp decompensation		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) None		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? NO	
22. I certify that (I) (this hospital) attended the deceased from 10-19-65 to 12/14/65 to 12/14/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J.P. Kokko		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/14/65	
23C. PHYSICIAN'S NAME (Type) J. P. Kokko		23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/20/65		24C. NAME OF CEMETERY or CREMATORY IMMANUEL CEMT.	
24D. LOCATION BALTO.		24E. (City, town, or county)		24F. (State) MD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 16 1965		25B. NAME OF REGISTRAR R. E. Sullivan		25C. FUNERAL DIRECTOR G. W. Hoffmann	
25D. ADDRESS 3218 Hudson St.					

Kindly see above

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDWARD ULRICH

2. DATE AND HOUR PRONOUNCED DEAD

12/14/65 7:15 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

733 S. Lakewood Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

6/13/1879

9. AGE (In years
last birthday)

86

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CITY POLICE DEPT.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

JOHN ULRICH

14. MOTHER'S MAIDEN NAME

ANNA HERGET

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

—

17. INFORMANT

ADDRESS

MRS. MARIE WITZKE 733 S. LAKEWOOD AVE.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Stab wound of head
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

733 S. Lakewood Ave.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12 6 65 about
4:00p

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

stabbed self in head with ice pick

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/14/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

12/16/65

23C. NAME OF CEMETERY or CREMATORY

MORELAND MEM.

23D. LOCATION

BALTO.

(City, town, or county)

(State)

MD.

24A. DATE REC'D BY HEALTH DEPT.

DEC 16 1965

24B. NAME OF REGISTRAR

R. E. F. F. F.

24C. FUNERAL DIRECTOR

G. V. Hoffmann

ADDRESS

3218 HUDSON ST.

VALLEY FORCE

ROAD CONTINUED

JOHN H. HARRIS
FARMER
WINDY HILL
VALLEY FORCE, IOWA

STATE OF IOWA

JOHN H. HARRIS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12808BIRTH NO. M 65 12808

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)
Roy MYERS

2. DATE AND HOUR PRONOUNCED DEAD

Dec. 11, 196511:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MarylandB. COUNTY 3-02

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1319 E. Baltimore Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

NEVER MARRIED

8. DATE OF BIRTH

10/30/05

9. AGE (In years last birthday)

60

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

SEAMAN

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

DAVID MYERS

14. MOTHER'S MAIDEN NAME

ELLA EDWARDS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

217-12-8648

17. INFORMANT

ADDRESS

ROBERT MYERS 911 MILTON AVE.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease(A) XXXXX

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

DATE SIGNED

Dec. 12, 1965

23A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

23B. DATE

12/15/65

23C. NAME of CEMETERY or CREMATORY

WOODLAWN

23D. LOCATION (City, town, or county)

BALTO. Co.

(State)

MD.

24A. DATE REC'D BY HEALTH DEPT.

DEC 16 1965

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Ger. Hoffmann 3218 HUDSON ST.

ADDRESS

WALTER FORGE

65 12809

BALTIMORE CITY HEALTH DEPARTMENT

65 12809

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

WILLIAM RAMPLEY

2. DATE AND HOUR PRONOUNCED DEAD

12, 12, 65

11.50 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

700 Fleet Street, Baltimore 2.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Baltimore, Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

844 West Baltimore Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 15, 1893

9. AGE (In years
last birthday)

72

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Farmer

10B. KIND OF BUSINESS OR INDUSTRY

Ret.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Philip Rampley

14. MOTHER'S MAIDEN NAME

Virginia Street

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes.

9/5/18 - 1/11/19

16. SOCIAL
SECURITY NO.

160-18-8254

17. INFORMANT

1113 Densford Rd
Mr. Arthur A. Rampley

ADDRESS

GLEN
BUNNIE

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) ARTERIOSCLEROTIC CARDIOVASCULAR
DUE TO DISEASE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Werner U. Spitz

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
12. 12. 65EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/15/65

23C. NAME of CEMETERY or CREMATORY

London National Cem. Balto. Md.

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 16 1965

24B. NAME OF REGISTRAR

Robert E. Johnson

24C. FUNERAL DIRECTOR

G. T. Schwab

ADDRESS

3512 FREDERICK AVE. (29)

19. 10. 1917

19. 10. 1917

19. 10. 1917

19. 10. 1917

19. 10. 1917

19. 10. 1917

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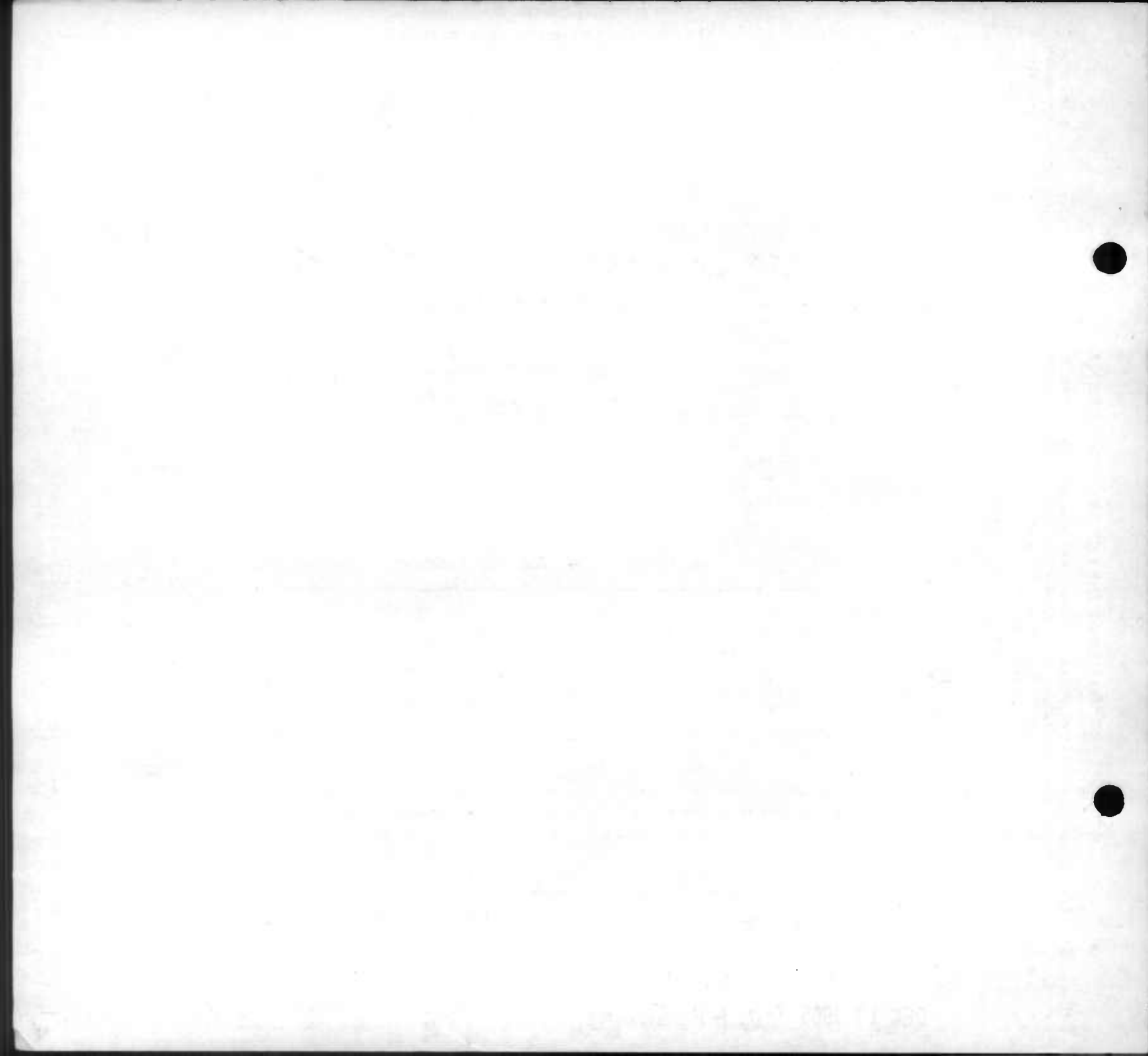
19. 10. 1917

19. 10. 1917

19. 10. 1917

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12810		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12810	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Claybourne Ellison H.</i>		2. DATE AND HOUR OF DEATH <i>12/15/65 9:15 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>620 N. Pulaski Street</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore, Maryland 21217</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore City Hospitals</i>		D. STREET ADDRESS (If rural, give location) <i>16-05</i>			
5. SEX <i>MALE</i>	6. RACE <i>Colored</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widower</i>	8. DATE OF BIRTH <i>7-16-98</i>	9. AGE (In years last birthday) <i>67</i>	10. If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SET LABORER</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>GEN CONTRACTOR</i>		11. BIRTHPLACE (State or foreign country) <i>NORBECR MD</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Rev. W. Ellison</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN Mary Rick's</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>217-03-3888</i>		17. INFORMANT'S ADDRESS <i>Records: BCH, 4940 Eastern Avenue</i>	
18. <i>450.01</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Aspiration of Food</i>		<i>Minutes</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Generalized arteriosclerosis with chronic brain syndrome</i>		<i>Years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Decubitus ulcers</i>			
19A. DATE OF OPERATION <i>11/30/65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Left femoral Artery Aneurysm</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>11/25</i> 19 <i>65</i> to <i>12/15</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>12/14</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Marc Asher</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>12/15/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Marc Asher</i>		23D. ADDRESS <i>M.D. 4940 Eastern Avenue, Baltimore, Maryland</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/22/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Not known</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 17 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>Marlene P. Hays</i>		ADDRESS <i>638 N. Gilman St</i>			



65 12811

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 12811

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WINSLOW LEWIS

2. DATE AND HOUR PRONOUNCED DEAD

12/14/65

3:15 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

628 Gilmore St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

628 N. Gilmore St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

6-15-1895

9. AGE (In years
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
during most of working life, even if retired)

RET. JANITOR

10B. KIND OF BUSINESS OR INDUSTRY

APT. BLDG.

11. BIRTHPLACE (State or foreign country)

CENTER CROSS VA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

BESSIE LEWIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WWI

16. SOCIAL
SECURITY NO.

218-10-2939

17. INFORMANT

Edith C. Johnson 5234 Irwin St PHILA. PA

ADDRESS

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

D

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/14/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/20/65

23C. NAME of CEMETERY or CREMATORY

BALTO NATIONAL

23D. LOCATION (City, town, or county) (State)

BALTO MD

24A. DATE REC'D BY HEALTH DEPT.

DEC 17 1965

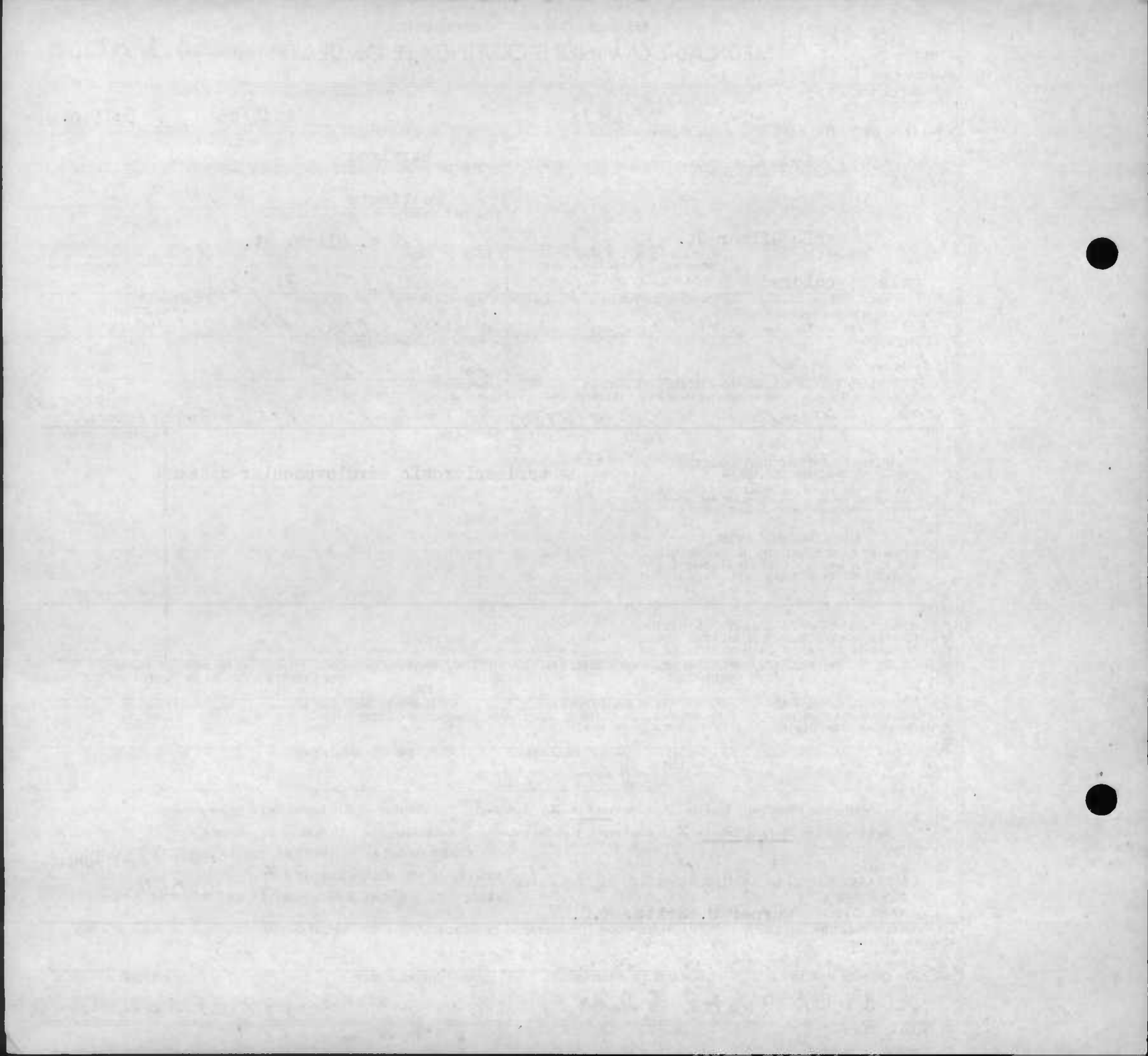
24B. NAME OF REGISTRAR

Robert E. Finkbeiner

24C. FUNERAL DIRECTOR

Marshall P. Hays 638 N Gilmore St

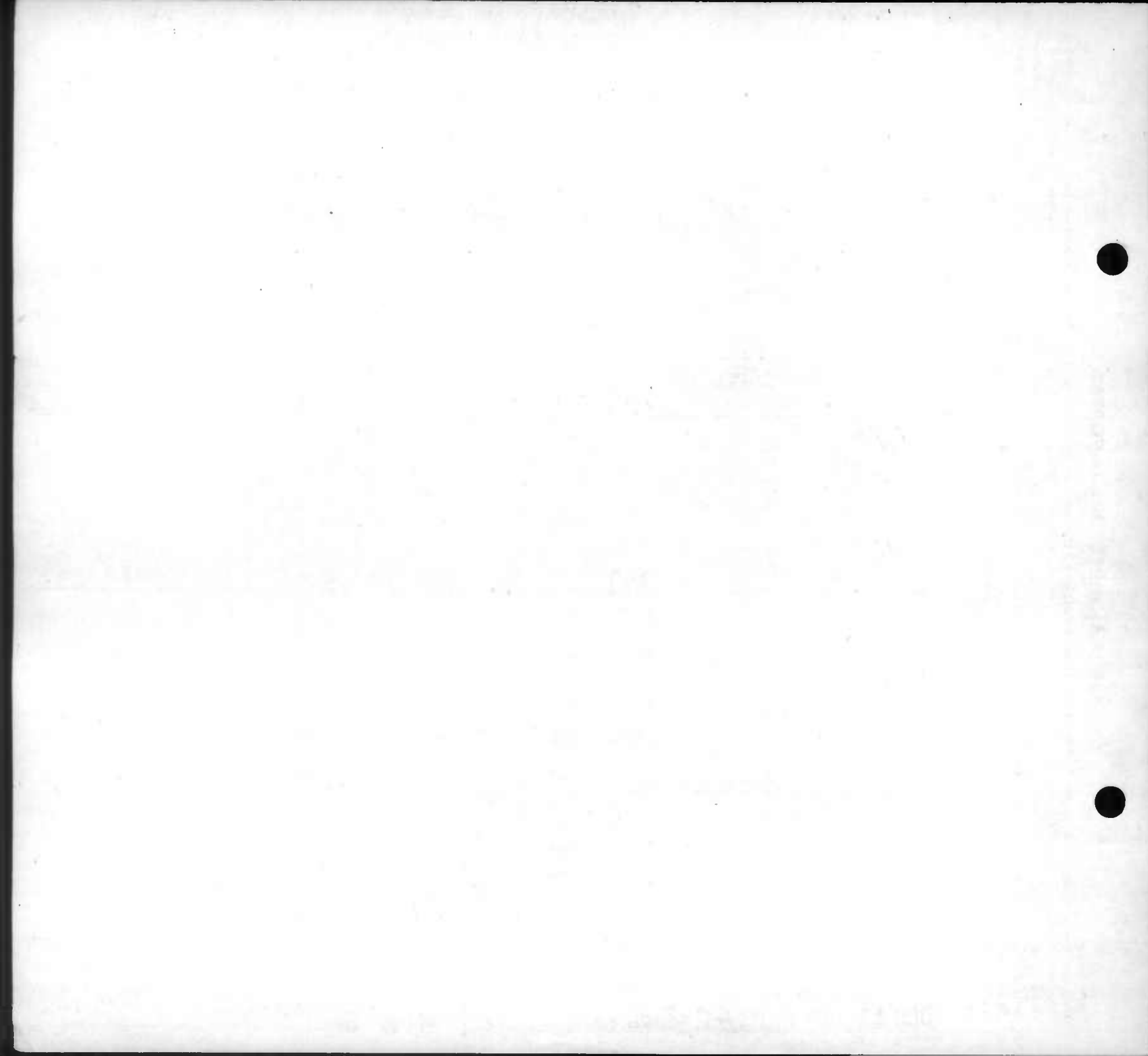
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

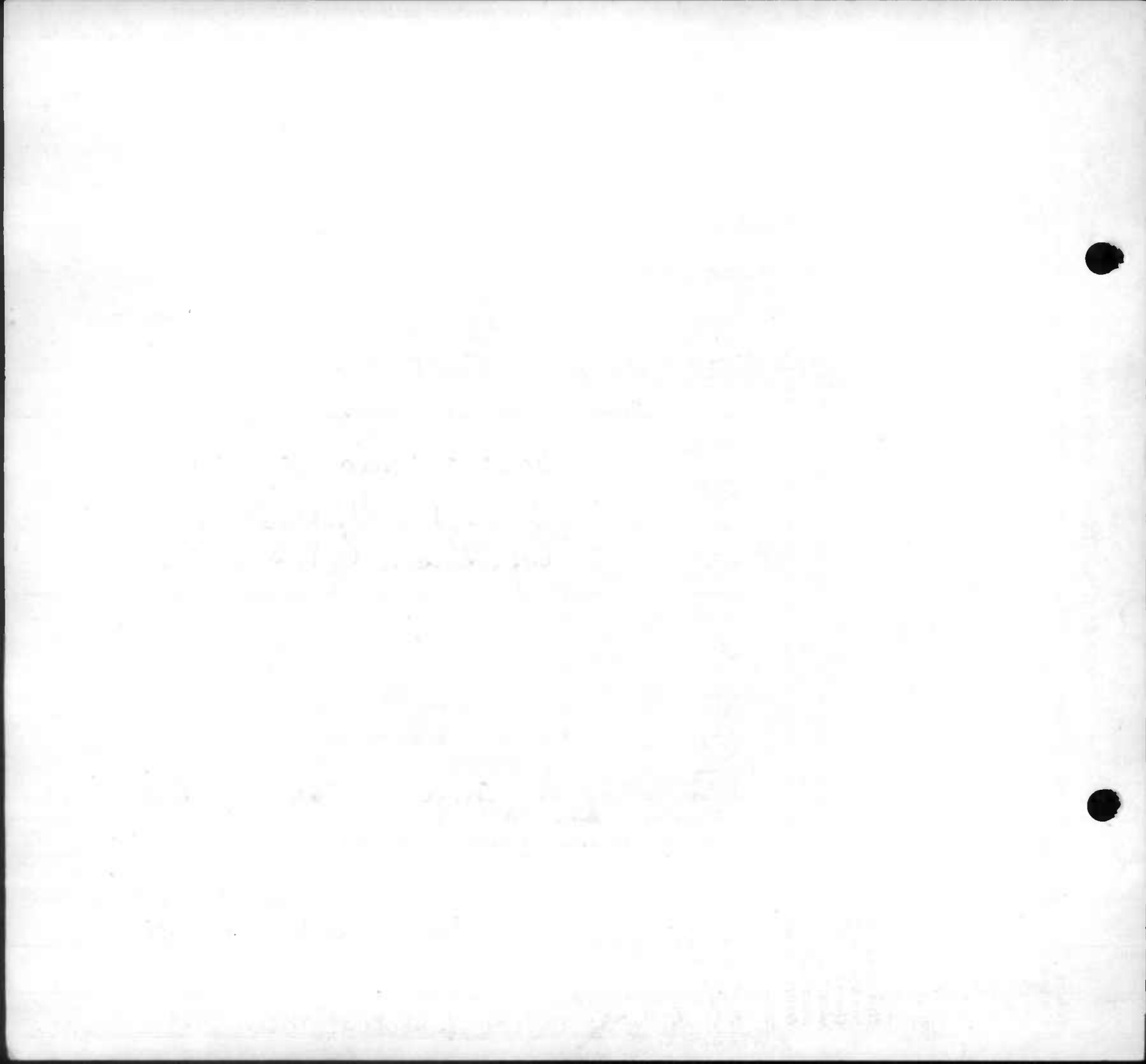
BIRTH NO. 65 12812		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 12812	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) IDA E. WITHERSPOON		2. DATE AND HOUR OF DEATH DEC. 14 - 1965 2:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 15-38		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 3500 FORREST PK. AVE		D. STREET ADDRESS (If rural, give location) 3500 FORREST PK. AVE		12. CITIZEN OF WHAT COUNTRY? USA	
5. SEX FE	6. RACE (Colored)	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11-24-1913	9. AGE (In years last birthday) 52	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAID		10B. KIND OF BUSINESS OR INDUSTRY HOSPITAL	11. BIRTHPLACE (State or foreign country) Calvert Co. MD		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME AMOS CONTER			14. MOTHER'S MAIDEN NAME ELLA FOOTE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-05-585	17. INFORMANT ROBERT WITHERSPOON		ADDRESS 3500 FORREST PK.
18. 170X I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Respiratory Failure			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Carcinoma Breast			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) _____			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 11 1965 to December 14 1965 , that (I) (we) last saw the deceased alive on December 11 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE I. Shorofsky		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/15/65	
23C. PHYSICIAN'S NAME (Type) SHOROFSKY		23D. ADDRESS M.D. 601 N. Monmouth & Balto 17, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/18/65		24C. NAME OF CEMETERY or CREMATORY WPA Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore 21225		25A. DATE REC'D BY HEALTH DEPT. DEC 17 1965			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Marshall P. Ligon			
25D. ADDRESS 638 N. Calmar St					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>65 12813</u>	
BIRTH NO. <u>65 12813</u>		M.E. CASE NO. <u>65 12813</u>		1. NAME OF DECEASED (Type or Print) <u>Marie Harris</u>		2. DATE AND HOUR OF DEATH <u>12-14-65</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>George Washington Carver Nursing Home</u>				A. STATE <u>MD</u> B. COUNTY <u>19-02</u>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>				D. STREET ADDRESS (If rural, give location) <u>109 N. Fulton Ave</u>			
5. SEX <u>Fe</u>	6. RACE <u>Col</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>W</u>	8. DATE OF BIRTH <u>2-3-1906</u>	9. AGE (In years last birthday) <u>59</u>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Thomas Harris</u>			14. MOTHER'S MAIDEN NAME <u>Florence Mitchell</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>213-65-4024</u>			17. INFORMANT <u>Morris Harris-1529 N. Fulton Ave</u>			ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>260X1</u>				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO <u>Cardiovascular Accident</u>			
ANTECEDENT CAUSES				(B) DUE TO <u>Diabetes Mellitus</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>Hypertensive C.V. Disease</u>							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Dec. 13</u> 19 <u>65</u> to <u>Dec</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Dec. 13</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>M. L. Weaver</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>M. L. Weaver</u>				23D. ADDRESS <u>1944 Druid Hill Ave</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-18-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 17 1965</u>		25B. NAME OF REGISTRAR <u>R. E. R. F. J. J. J.</u>		25C. FUNERAL DIRECTOR <u>J. J. J. J. J.</u>		ADDRESS <u>Baltimore - Balto. Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

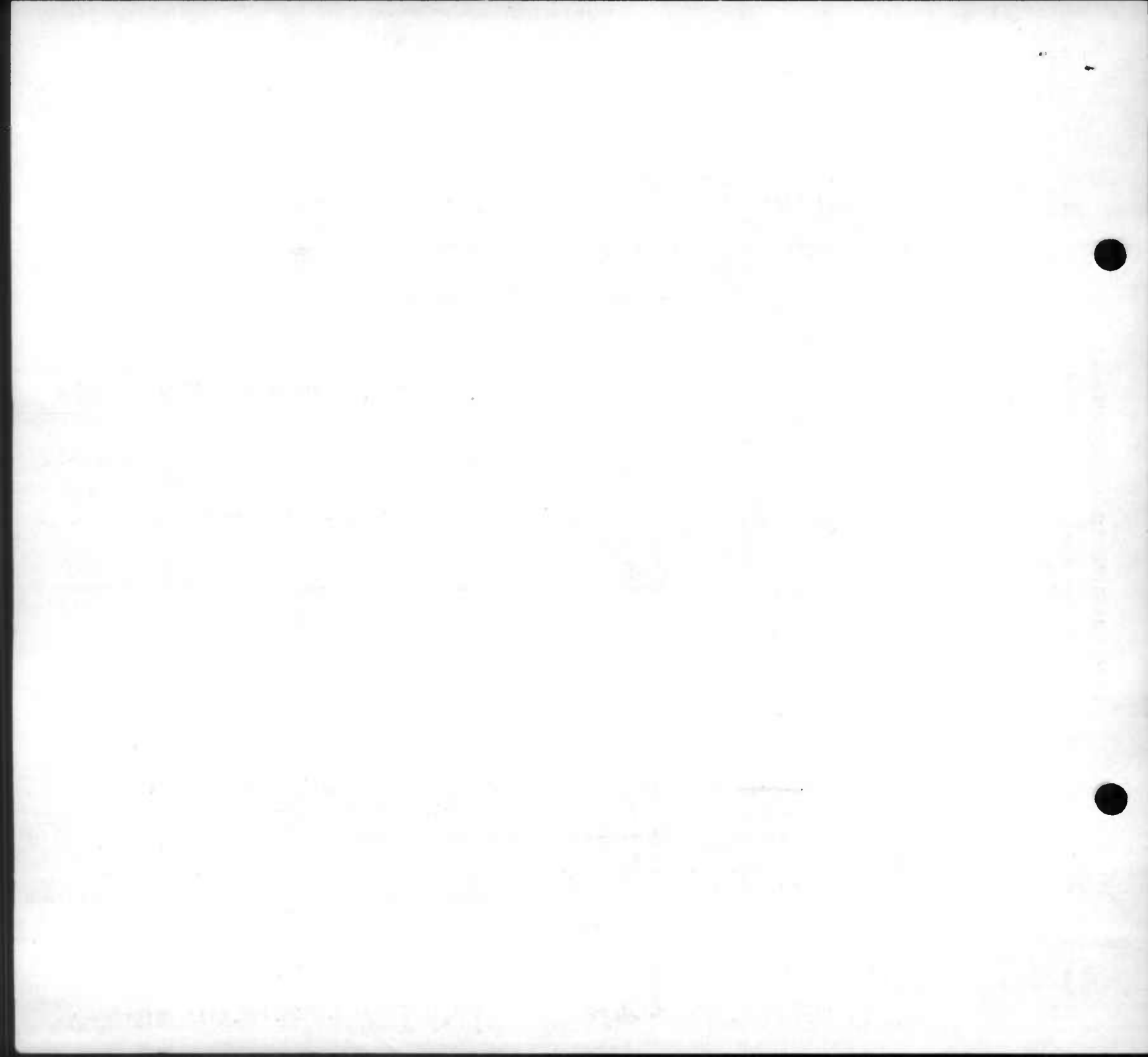
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 12814				
BIRTH NO. 65 12814		M.E. CASE NO.			2. DATE AND HOUR OF DEATH Dec 15 1965 1910 A.M.				
1. NAME OF DECEASED (Type or Print) <i>NOHA Rabinowitz, Debra</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>U.S.A.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>42 Sinai Hospital of Baltimore</i>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>RANDALLSTOWN.</i>				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>42 Sinai Hospital of Baltimore</i>					D. STREET ADDRESS (If rural, give location) <i>9014 Samoset Rd</i>				
5. SEX <i>F</i>	6. RACE <i>W.</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>NEVER MARRIED</i>		8. DATE OF BIRTH <i>4-11-1951</i>	9. AGE (In years last birthday) <i>11</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Child</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>LAURENCE Rabinowitz</i>					14. MOTHER'S MAIDEN NAME <i>Ruth ENGEL</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO. <i>NO</i>		17. INFORMANT <i>LAURENCE Rabinowitz</i>			ADDRESS <i>9014 Samoset Rd</i>	
18. <i>35-5X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) <i>SPONTANEOUS PNEUMOTHORAX</i> DUE TO (B) <i>ATAXIA TELANGECTASIA</i> DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH <i>11 yrs.</i>	
19A. DATE OF OPERATION <i>0 NONE</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Nov 29 1965</i> to <i>Dec 15 1965</i> , that (I) (we) last saw the deceased alive on <i>Dec 15 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Robert G. Thompson</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>Dec 15, 1965</i>	
23C. PHYSICIAN'S NAME (Type) <i>Robert G. Thompson</i>					23D. ADDRESS <i>Sinai Hospital</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>12/16/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>HEBREW YOUNG MEN</i>			24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 17 1965</i>			25B. NAME OF REGISTRAR <i>DR. J. E. F. J. J.</i>			25C. FUNERAL DIRECTOR <i>SEL ANDERSON & BROS INC 6010 REISTERSTOWN</i>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

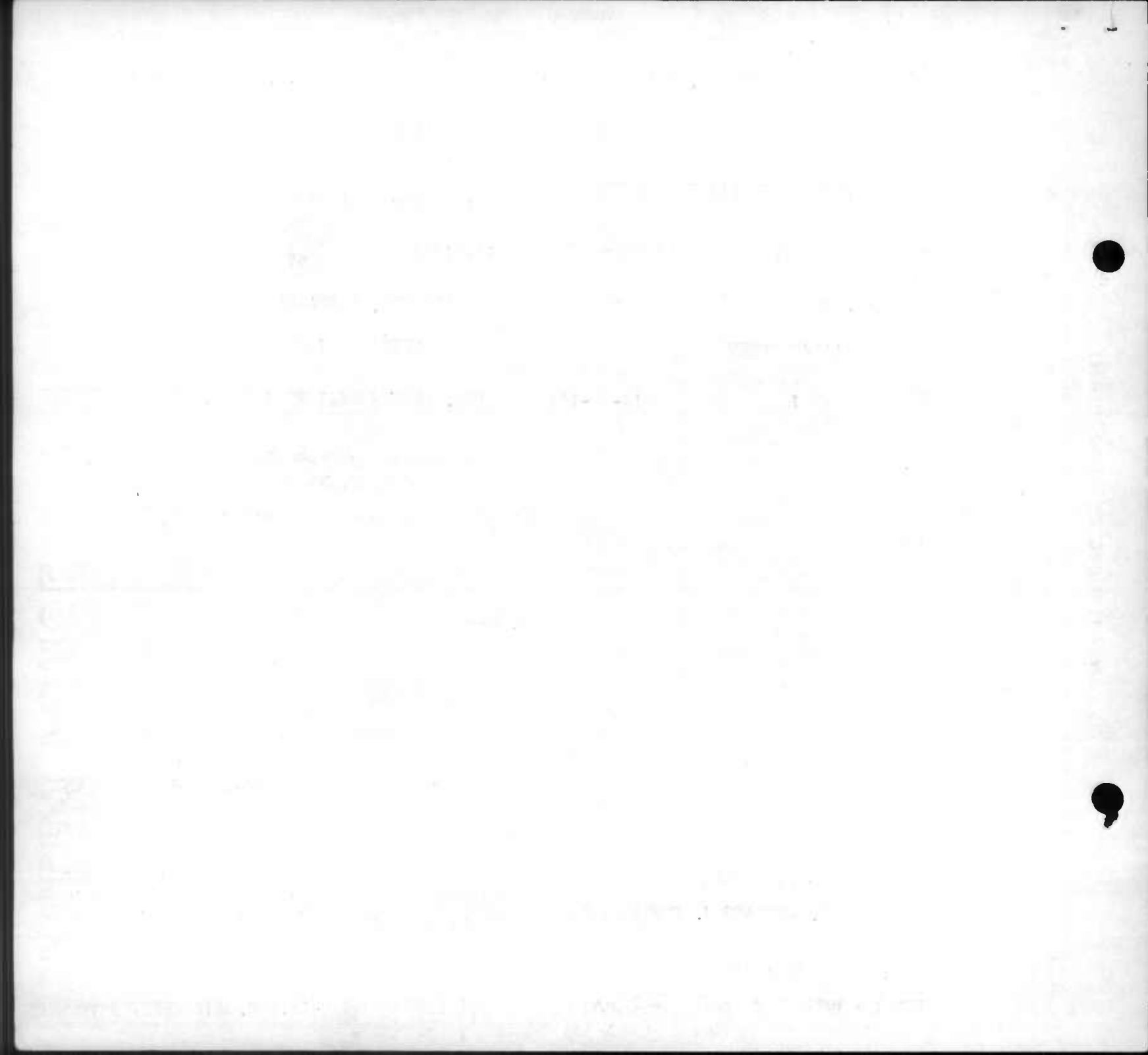
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 12815	
BIRTH NO. 65 12815		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) ANNA BLOOM		DECEMBER 14, 1965 9P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MARYLAND			
90 PALL MALL NURSING HOME 4601 PALL MALL ROAD		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 3531 CLAREMONT STREET			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 1875	9. AGE (In years last birthday) 90	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MR. ROBERT P. BLOOM 6203 WESTERN RUN DRIVE	
18. 450.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Acute pneumonia DUE TO (B) Generalized arteriosclerosis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 week Several years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 11 1965 to Dec 14 1965, that (I) (we) lost saw the deceased alive on Dec 14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Seymour H. Rubin				23B. DATE SIGNED 12/15/65	
23C. PHYSICIAN'S NAME (Type) Seymour H. Rubin				23D. ADDRESS 5415 Park Heights Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/16/65		24C. NAME OF CEMETERY or CREMATORY KOUNA	
24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1965		25B. NAME OF REGISTRAR R. L. E. J. Rubin		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

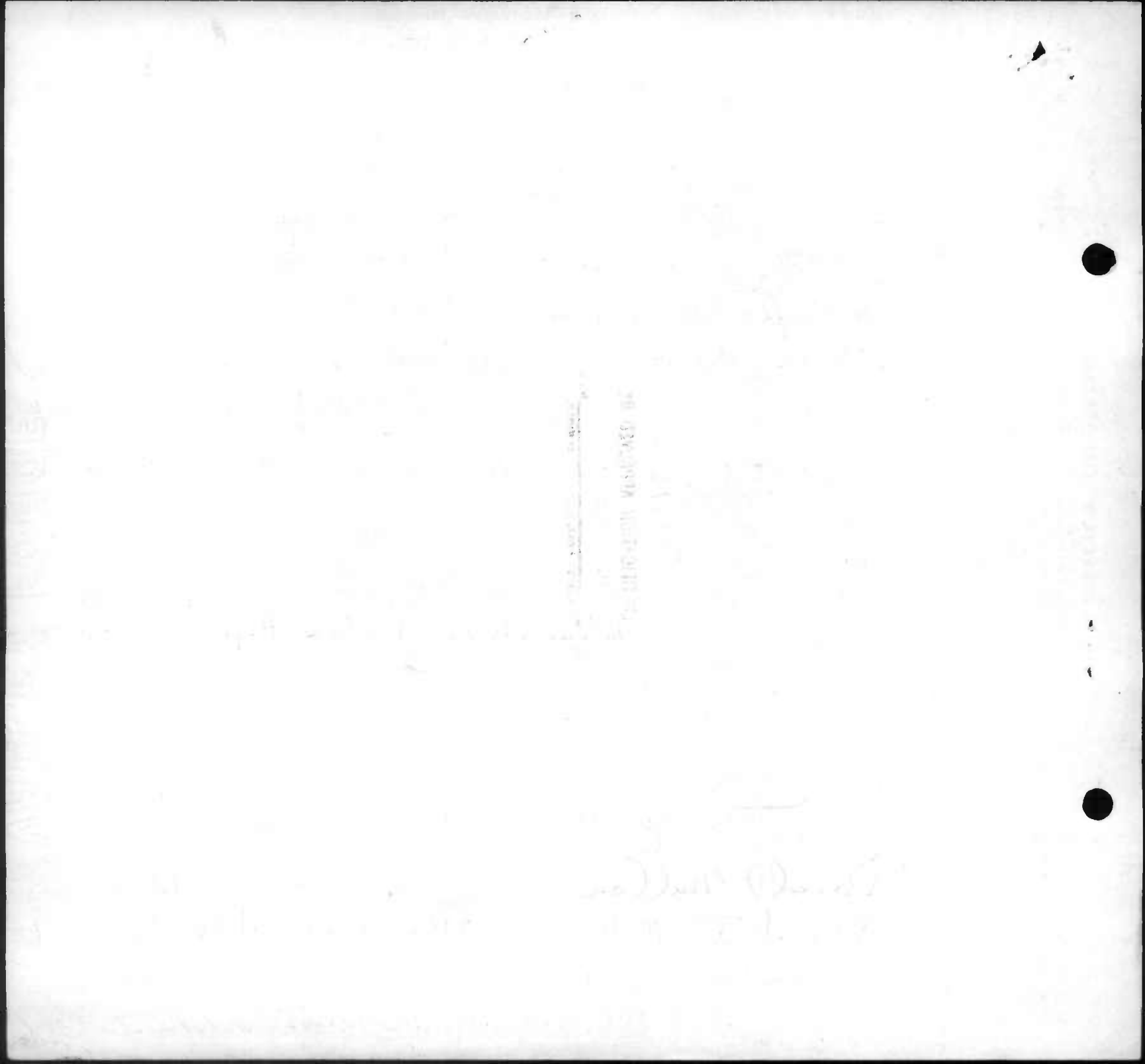
W-436		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12816	
BIRTH NO. 65 12816		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) EMANUEL J. WALTERS (COHEN)		2. DATE AND HOUR OF DEATH DECEMBER 13, 1965 11:15 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 26-71			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1005 SOUTH CLINTON STREET		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 1005 SOUTH CLINTON STREET			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5/4/1896	9. AGE (In years last birthday) 69	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY MEAT		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME WILLIAM COHEN			
14. MOTHER'S MAIDEN NAME VETTA ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW 1			
16. SOCIAL SECURITY NO. 214-03-1183		17. INFORMANT ADDRESS MRS. BERTHA WALTERS 1005 S. CLINTON STREET			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 15-8X Sarcinomatosis metastases + ascites.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 1 year	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO Retro-peritoneal sarcoma. 1 year	
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 9 1965 to Dec 13 1965, that (I) (we) last saw the deceased alive on Dec 13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bernard J. Cohen				23B. DATE SIGNED 12-14-65	
23C. PHYSICIAN'S NAME (Type) DR. BERNARD J. COHEN				23D. ADDRESS The Maryland Apt 3501 St. Paul St.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/16/65		24C. NAME of CEMETERY or CREMATORY HEBREW YOUNG MEN	
24D. LOCATION BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. DEC 17 1965			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 12817	
BIRTH NO. 65 12817		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Celia Kraoetz		2. DATE AND HOUR OF DEATH 12-11-65 7:00 PM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY 15-12			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Belvedere, House in the Pine w. Belvedere Ave				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
D. STREET ADDRESS (If rural, give location) 2403 Shirley Ave							
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 4/6/1884	9. AGE (in years last birthday) 81	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nathan Wohl				14. MOTHER'S MAIDEN NAME Sarah?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Louis B. Krantz - apt c		ADDRESS Drone Western Park	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 493 X HE 902.7		19. CAUSE OF DEATH Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 24 hours			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Arteriosclerosis, Fracture Hip		#1 years #2 months			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House in pine		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2403 Shirley Ave			
21D. TIME OF INJURY (APPROX.) 7 24 65		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? fell from chair			
22. I certify that (I) (this hospital) attended the deceased from 12-11-65 to 12-11-65 , that (I) (we) last saw the deceased alive on 12-11-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE David J. Miller				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-11-65	
23C. PHYSICIAN'S NAME (Type) David J. Miller				23D. ADDRESS 2106 Cartersdale Rd #9			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/13/65		24C. NAME OF CEMETERY or CREMATORY Bnai Reuben		24D. LOCATION (City, town, or county) (State) Bredale, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR 9650		25C. FUNERAL DIRECTOR Sal... - 6010 Rest. Road		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 12818				
BIRTH NO. 65 12818									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) SARAH REBECCA FREEMAN					2. DATE AND HOUR OF DEATH 12-15-65 1 04⁵ A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ESPLANADE APTS APT 4H 2525 EUTAW PLACE					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 13-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2525 EUTAW PLACE APT 4H				
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 1/15/1871	9. AGE (In years last birthday) 94	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) LITHUANIA			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY KRAMER					14. MOTHER'S MAIDEN NAME BESSIE LEAH CHOR				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. NO		17. INFORMANT MR. ELLIS FREEMAN 2525 EUTAW PLACE				ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 151X1 Carcinoma of stomach 1 mo(?)					CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO				(B) DUE TO
					(C) DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from Sept 19 55 to Dec 15 19 65 , that (I) (we) last saw the deceased alive on Dec 14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Irvin Sauber					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 12-15-65	
23C. PHYSICIAN'S NAME (Type) DR. IRVIN SAUBER					23D. ADDRESS 6905 Park Hyts Ave				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/16/65		24C. NAME OF CEMETERY or CREMATORY HEBREW YOUNG MEN			24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1965			25B. NAME OF REGISTRAR Robert E. Johnson			25C. FUNERAL DIRECTOR SQL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD			

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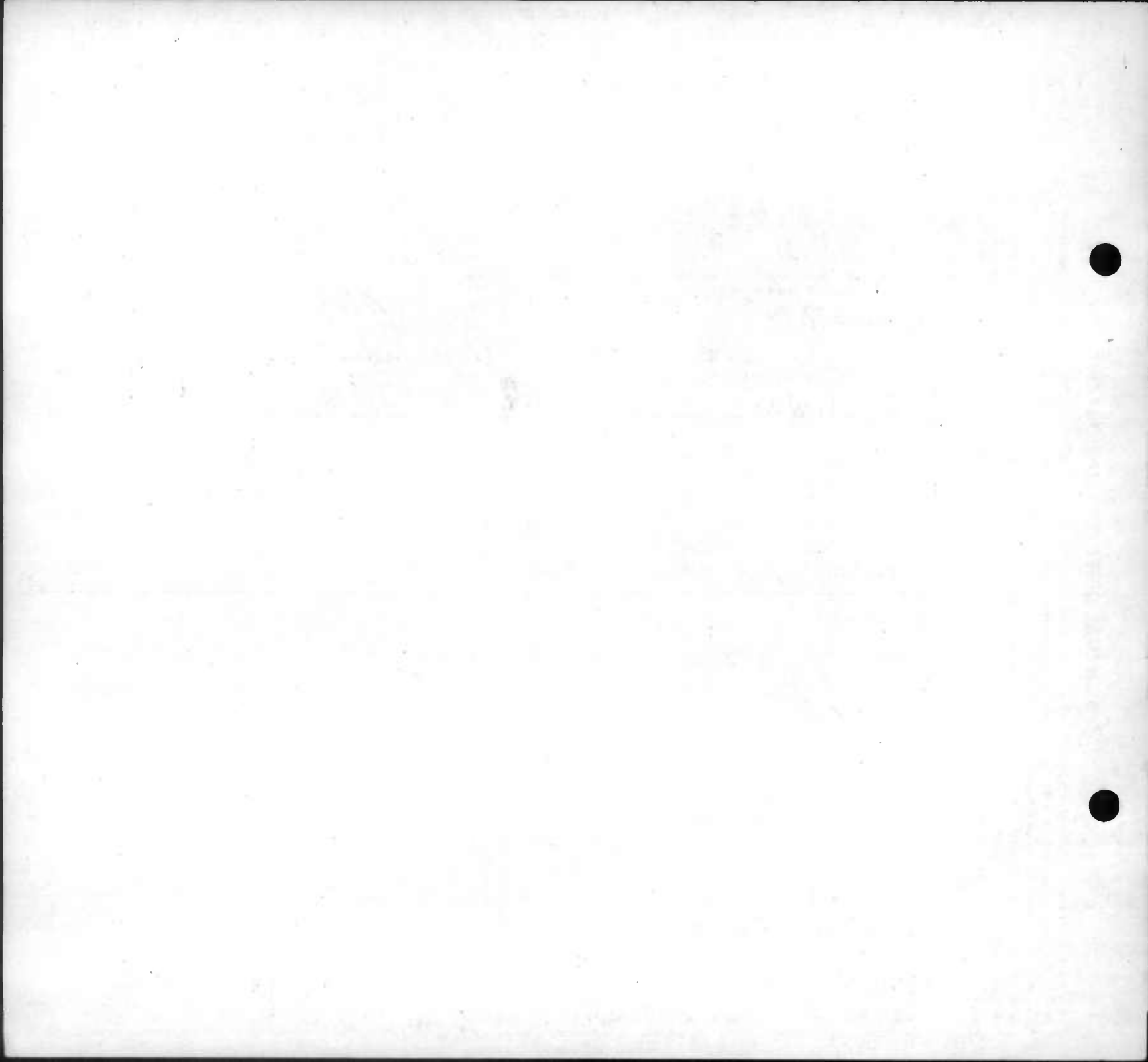
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 12819</u>	
BIRTH NO. <u>65 12819</u>				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Charles Smallwood</u>		2. DATE AND HOUR OF DEATH <u>12-12-65</u> <u>1:35</u> PM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>Maryland</u> B. COUNTY <u>13-06</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
				D. STREET ADDRESS (If rural, give location) <u>3423 Roland Ave</u>	
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>single</u>	8. DATE OF BIRTH <u>12-7-04</u>	9. AGE (In years lost birth day) <u>58</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machine operator</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Pooles Foundry</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>Jefferson Smallwood</u>			14. MOTHER'S MAIDEN NAME <u>Amanda Bookman</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW2-</u>		16. SOCIAL SECURITY NO. <u>215-07-6759</u>		17. INFORMANT ADDRESS <u>Norothy Wood - Canada same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>420.1 I</u> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Acute Anterior Myocardial Infarction</u>				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>ASCD</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Work Not White At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR? <u>1:08 PM</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>12-12-65</u> 19 <u>65</u> to <u>12-12-65</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12-12-65</u> 1:35 PM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Miriam L Cohen</u>				23B. DATE SIGNED <u>12-12-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>MIRIAM L COHEN</u>				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-15-65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 17 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Jones</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Franklin St 814 W 36 St</u>	

Miriam Cohen



45-37-03
JJ

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)65 12820
Anna T. Kalendek

2. DATE AND HOUR OF DEATH

12-14-65 9:10 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

2620 FAIT AVE.

5. SEX

F

6. RACE

Cauc.

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

July 17-1894 71

9. AGE (In years
lost birthday)If Under 1 Yr.
Months: DaysIf Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired, Wendell Ruff Packing Co.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Francis Jagielski

14. MOTHER'S MAIDEN NAME

Ida Grzechowiak

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL
SECURITY NO.
213-03-1456

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 EASTERN AVENUE #21224

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Seizures + coma

(B) DUE TO

congestive heart failure

(C) DUE TO

H.A.S.C.V.D.

INTERVAL BETWEEN
ONSET AND DEATH

6 days

3 weeks

7 years +

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-5 19 65 to 12-14 19 65.
that (I) (we) last saw the deceased alive on 12-14 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Alan E. Oestrich

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

12-14-65

23C. PHYSICIAN'S
NAME (Type)

DR. ALAN E. OESTRICH

M.D.

23D. ADDRESS

4940 EASTERN AVENUE #21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Dec. 18-1965

24C. NAME OF CEMETERY or CREMATORY

Holy Rosary

24D. LOCATION

(City, town, or county)

(State)

German Hill Rd. Dundalk, Md. 21222

25A. DATE REC'D BY HEALTH DEPT.

DEC 17 1965

25B. NAME OF REGISTRAR

John J. Duda

25C. FUNERAL DIRECTOR

ADDRESS

JOHN J. DUDA 7922 Wise Ave. Dundalk, Md. 21222

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Page 1

15-14-1952

Amesbury, Mass.

15-14-1952

F Case

15-14-1952
3 weeks
1 year +

serum + common
conjugate heart failure
H.A.S.C.V.D.

No

15-14-1952

15-14-1952

15-14-1952

15-14-1952

Amesbury, Mass.

15-14-1952

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		65 12821		CITY OF BALTIMORE HEALTH DEPARTMENT		Registered No. 65 12821	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MILDRED LOUISE FOX				2. DATE AND HOUR OF DEATH DECEMBER 13, 1965 11:40 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND, BALTIMORE B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5106 NORWOOD RD			
5. SEX F	6. RACE CHUC	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 5-7-99	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOSEPH FRANCIS JOSEPH FOX				14. MOTHER'S MAIDEN NAME MARY BLANCHE STEVENSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS PATIENT		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 465 XI				CAUSE OF DEATH (A) Pulmonary embolism DUE TO (B) fat DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 20 19 65 to DECEMBER 13 19 65 , that (I) (we) last saw the deceased alive on DECEMBER 13 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Samuel C. Gresham				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-13-65	
23C. PHYSICIAN'S NAME (Type) SAMUEL C. GRESHAM				23D. ADDRESS M.D. UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/17/1965		24C. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1965		25B. NAME OF REGISTRAR DEC 17 1965		25C. FUNERAL DIRECTOR ADDRESS Eugenia K. Seitz 5209 York Road Balto. Md.			

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M-360

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 12822 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12822

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) GUY L MITTER				2. DATE AND HOUR PRONOUNCED DEAD 12/14/65 4:15 p. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD St. Agnes Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY A A C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Linthicum 52-00 D. STREET ADDRESS (If rural, give location) 1210 Furnace Rd.			
5. SEX male		6. RACE white		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH June 17, 1922	
9. AGE (In years last birthday) 43		10. UNDER 1 Yr. If Under 24 Hrs. Months Days Hours Min.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Newburg, W. Va.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Russell G. Mitter				14. MOTHER'S MAIDEN NAME M. Menear			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 11				16. SOCIAL SECURITY NO. 236-24-5710		17. INFORMANT ADDRESS Mrs. Mildred Mitter, Same	
18. 722.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) DUE TO (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz EXAMINER'S NAME (Type) Werner U. Spitz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/15/65			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 12-18-1965		23C. NAME of CEMETERY or CREMATORY Meadowridge		23D. LOCATION (City, town, or county) (State) E, kridge, Md	
24A. DATE REC'D BY HEALTH DEPT. DEC 17 1965		24B. NAME OF REGISTRAR R. E. F. Jones		24C. FUNERAL DIRECTOR F. C. Higinbotham		ADDRESS Ellicott City, Md	

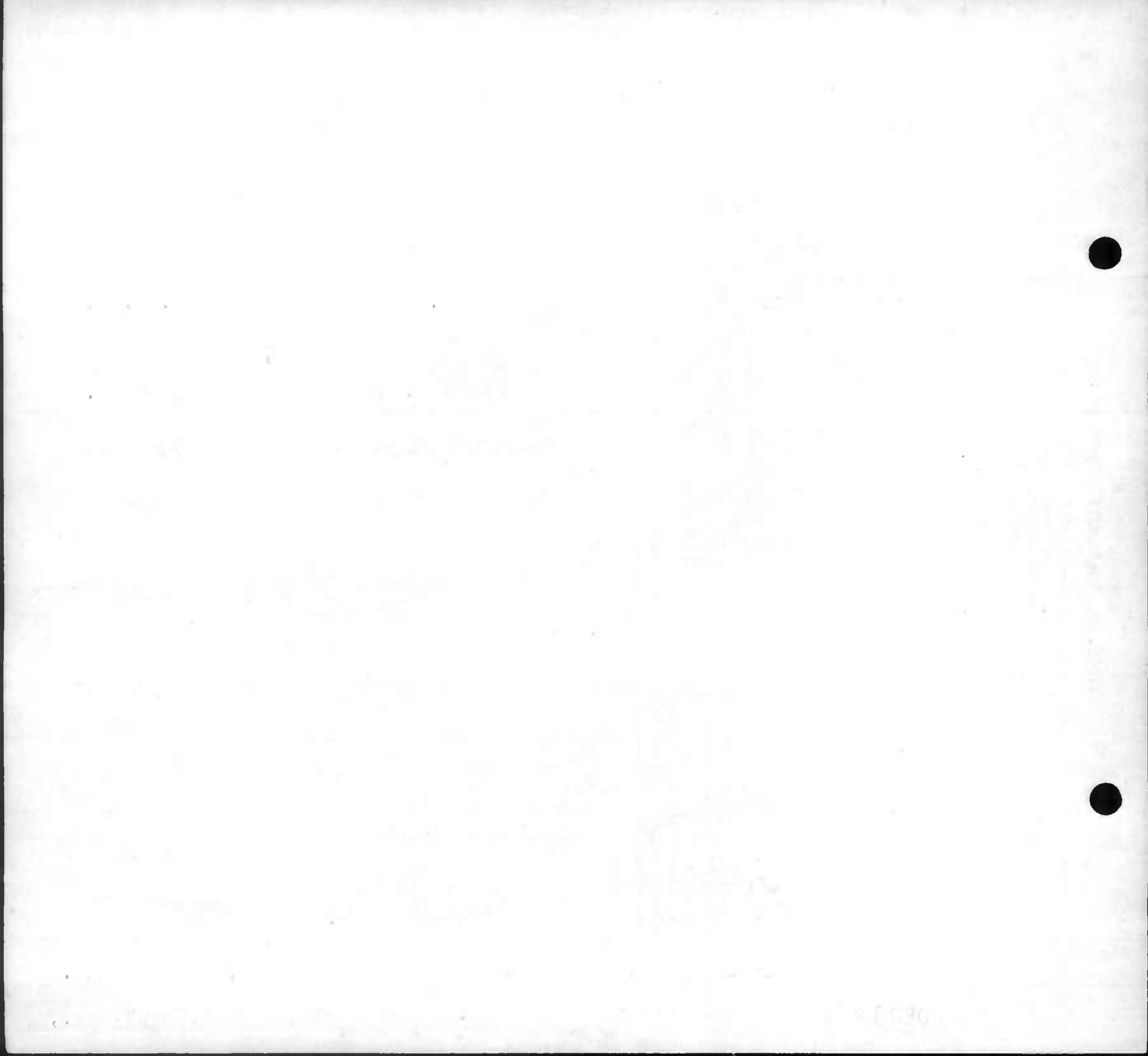
WALLEN BORG

1-24-1941

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12823	
BIRTH NO. 65 12823		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) LEIMBACH George H		2. DATE AND HOUR OF DEATH 13-Dec-65 2:55P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND. B. COUNTY 25-31	
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
D. STREET ADDRESS (If rural, give location) 400 Colleen Rd APT E			
5. SEX MALE	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7-24-89
9. AGE (In years last birthday) 76		10. CITIZEN OF WHAT COUNTRY? U. S. A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Funeral Director		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME George H. Leimbach		14. MOTHER'S MAIDEN NAME Louise ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mabel A. Leimbach		ADDRESS 400 Colleen Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 422.1 I (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE		INTERVAL BETWEEN ONSET AND DEATH 19 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIO SCLEROTIC Cardio VASCULAR DISEASE		YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ARTERIO SCLEROTIC Cerebral VASCULAR DISEASE		SEVERAL YEARS	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PARKINSONS DISEASE	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 24 Nov 1965 to 13-Dec 1965 , that (2) (we) last saw the deceased alive on 13 Dec 1965 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.			
23A. SIGNATURE T.C. Cullis		23B. DATE SIGNED 13-Dec-65	
23C. PHYSICIAN'S NAME (Type) T.C. Cullis		23D. ADDRESS Md. Maryland General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-16-1965	24C. NAME OF CEMETERY or CREMATORY Loudon Park	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1965		25B. NAME OF REGISTRAR G. Howard Strong	
25C. FUNERAL DIRECTOR 3207 W. North Ave.,		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 12824					CERTIFICATE OF DEATH					Registered No. 65 12824				
1. NAME OF DECEASED (Type or Print) CARRIE E. WYATT					2. DATE AND HOUR OF DEATH 12/14/65 7:20 A.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GEN. HOSP					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO CITY CITY					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO 9-02				
D. STREET ADDRESS (If rural, give location) 1521 TUNLAW RD					5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED					8. DATE OF BIRTH 6/12/83 9. AGE (In years last birthday) 82				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10B. KIND OF BUSINESS OR INDUSTRY at home					11. BIRTHPLACE (State or foreign country) BALTO Md.				
12. CITIZEN OF WHAT COUNTRY? USA					13. FATHER'S NAME ? Knouse					14. MOTHER'S MAIDEN NAME Carrie Pfafenbach				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS Mabel A. Paulus, dght. 2847 Mayfield Ave.,				
18. 5421 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Perforated jejunal ulcer										CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) YES				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES					21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?					22. I certify that (I) (this hospital) attended the deceased from 12/12 19 65 to 12/14 19 65 , that (I) (we) last saw the deceased alive on 7 AM 12/14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE D. A. Bulotta					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 12/14/65				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D.									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 12/18/65					24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery				
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					25A. DATE REC'D BY HEALTH DEPT. DEC 17 1965					25B. NAME OF REGISTRAR Robert E. Schumaker				
25C. FUNERAL DIRECTOR Schumaker Funeral Home, Inc.					ADDRESS 3331-Brooks Lane									

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BIRTH NO. 65 12825 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12825

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ANNE FENNINGTON		2. DATE AND HOUR PRONOUNCED DEAD 12/14/65 11:30 a.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3724 Echodale Ave.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3724 Echodale Ave.	
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 2/6/1907
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home	9. AGE (In years last birthday) 58
13. FATHER'S NAME John L. Jeskey		14. MOTHER'S MAIDEN NAME Marie Bower	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	11. BIRTHPLACE (State or foreign country) Baltimore, Md.
		17. INFORMANT George J. Fennington, husband,	12. CITIZEN OF WHAT COUNTRY?

MEDICAL CERTIFICATION	18. CAUSE OF DEATH 241X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bronchial asthma (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
	19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes
	21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
	21F. HOW DID INJURY OCCUR?			
	22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
	ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/14/65	
	23A. BURIAL CREMATION, REMOVAL (Specify) Burial	23B. DATE 12/17/65	23C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	23D. LOCATION (City, town, or county) (State) Baltimore, Md.
24A. DATE REC'D BY HEALTH DEPT. DEC 17 1965		24B. NAME OF REGISTRAR P. J. P. [Signature]	24C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. ADDRESS 3331 Brehms Lane	

WESTERN UNION

TELEPHONE

NEW YORK

10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 12826		CERTIFICATE OF DEATH		Registered No. 65 12826	
1. NAME OF DECEASED (Type or Print) James Andrew Lorber Sr.				2. DATE AND HOUR OF DEATH Dec. 12, 1965 3:15 P. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-34 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3801 Hamilton Avenue					
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH July 23, 1902	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: Hours: Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plant Superintendant		
10B. KIND OF BUSINESS OR INDUSTRY Balto. Brick Co.			11. BIRTHPLACE (State or foreign country) Balto. Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Lorber				14. MOTHER'S MAIDEN NAME Margaret Maier					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 213-03-0269		17. INFORMANT James A. Lorber Jr.			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Acute Myocardial Infarction DUE TO (B) Hypertension DUE TO (C) _____			INTERVAL BETWEEN ONSET AND DEATH — year		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from August 1962 to Dec 12 1965 , that (I) (we) last saw the deceased alive on November 15 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.									
23A. SIGNATURE Albert O. Bradley						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/13/65	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-16-65		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1965		25B. NAME OF REGISTRAR Robert P. Johnson		25C. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd.		ADDRESS 21206			

Mr. O. Dwyer

James H. Brown

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				65 12827	
CERTIFICATE OF DEATH				Registered No.	
BIRTH NO. 65 12827					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Albertha L. Loftus		2. DATE AND HOUR OF DEATH Dec. 14, 1965 10 ³⁰ a M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1220 Battery Ave		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 24-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1220 Battery Ave			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 8 9 1884	9. AGE (In years last birthday) 81	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Indiana	
12. CITIZEN OF WHAT COUNTRY? U S A					
13. FATHER'S NAME Joseph Loftus		14. MOTHER'S MAIDEN NAME Sarah E. Loftus			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Joseph L. Loftus 1220 Battery Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 422.1 I ACUTE CARDIAC FAILURE INTERVAL BETWEEN ONSET AND DEATH 1 day		CAUSE OF DEATH (A) DUE TO Arterio-Sclerotic Cardiovascular Disease (B) DUE TO Coronary Arteriosclerosis (C) DUE TO Myocardial Infarction			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/19 to 12/14 1965, that (I) (we) last saw the deceased alive on 12/14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph G. Laukaitis M.D.				23B. DATE SIGNED 12/15/65	
23C. PHYSICIAN'S NAME (Type) JOSEPH G. LAUKAITIS M.D.				23D. ADDRESS 679 Washington Blvd Baltimore 30 Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12 17 65		24C. NAME OF CEMETERY or CREMATORY Meadowrdige	
24D. LOCATION (City, town, or county) (State) Dorsey, Howard Co. Md.					
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1965		25B. NAME OF REGISTRAR O. E. H. [Signature]		25C. FUNERAL DIRECTOR Mel Cully	
ADDRESS 130 E. Port Ave					

George Washington
Washington
George Washington

1797
1797
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Joseph C. Brown
Joseph C. Brown

1797
1797

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12828	
65 12828		CERTIFICATE OF DEATH	
BIRTH NO.		DATE AND HOUR OF DEATH	
M.E. CASE NO.		Dec. 15, 1965 6:15 P.M.	
1. NAME OF DECEASED (Type or Print) <i>Dennis Rice</i>		2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Montebello State Hospital</i>		A. STATE <i>Maryland</i> B. COUNTY <i>20-07</i>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
		D. STREET ADDRESS (If rural, give location) <i>3915 N. Mulberry St.</i>	
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>10-15-99</i>
			9. AGE (In years last birthday) <i>66</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired.</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>
13. FATHER'S NAME <i>Will Rice</i>		14. MOTHER'S MAIDEN NAME <i>Rena Kane</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-10-1834</i>	
		17. INFORMANT <i>Hospital chart</i>	
		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>162.1 I</i> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
ANTECEDENT CAUSES		(A) <i>Bronchogenic Carcinoma</i> DUE TO	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Unknown cause</i> DUE TO	
		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Arteriosclerotic Heart Disease</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Dec 7 1965</i> to <i>December 15 1965</i> , that (I) (we) last saw the deceased alive on <i>December 15 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Cesar J. Pellerano</i>		23B. DATE SIGNED <i>Dec 15, 1965</i>	
23C. PHYSICIAN'S NAME (Type) <i>Cesar J. Pellerano</i>		23D. ADDRESS <i>Montebello State Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-30-65</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 17 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>	
25C. FUNERAL DIRECTOR <i>Harry H. Kelly</i>		ADDRESS <i>1348 N. Calhoun St.</i>	

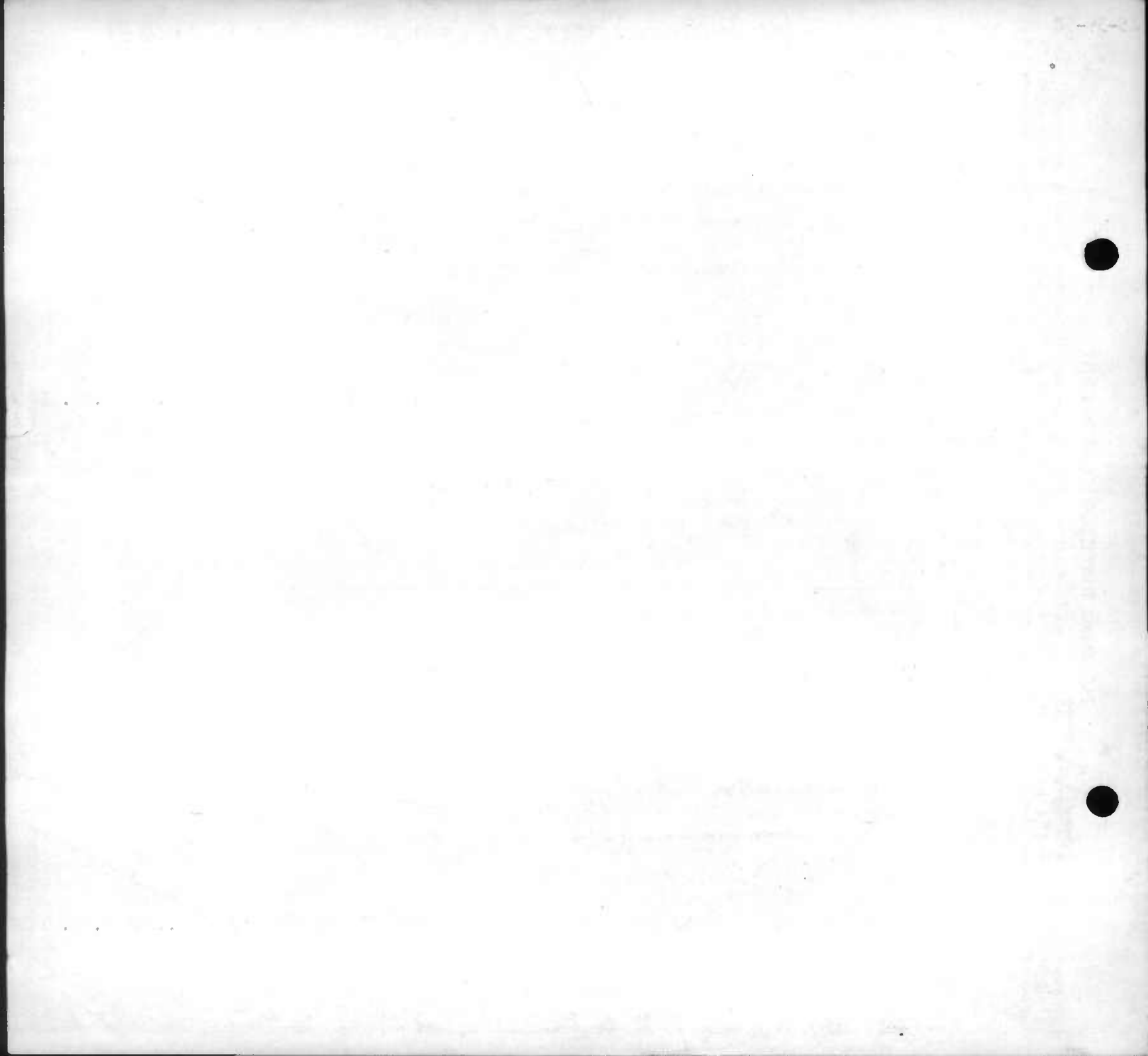
C-345 PUB

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 50-8 EV. 1/65

BIRTH NO. 65 12829		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12829	
M.E. CASE NO. 45-39-58		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CATALDI ANTHONY		2. DATE AND HOUR OF DEATH 12/13/65 11:38 pm.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1902			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore city Hospitals. B3 N.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO 21223 007.			
		D. STREET ADDRESS (If rural, give location) 119 N. FULTON AV.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED	8. DATE OF BIRTH 4.29.23	9. AGE (In years last birthday) 42	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ANTHONY		14. MOTHER'S MAIDEN NAME MARY.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH4940 Eastern Avenue, Balto. Md. 21224	
18. 146X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Nasopharyngeal carcinoma DUE TO		1 year.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Pulmonary embolus.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/18 1965 to 12/13 1965, that (I) (we) lost saw the deceased olive on 12/13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Kristin G. Edmundson		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/13/65	
23C. PHYSICIAN'S NAME (Type) K. EDMUNDSSON		23D. ADDRESS BCH 4940 Eastern Ave., Balto. Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/17/65		24C. NAME of CEMETERY or CREMATORY New Cathedral	
24D. LOCATION (City, town, or county) (State) Balto. 29 Md		25A. DEC REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Wesley J. B. 4101 Edmondson	
25C. FUNERAL DIRECTOR ADDRESS					



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BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 12830 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12830

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) JEANNETTA BREIDA FORD JANETTE FORD			2. DATE AND HOUR PRONOUNCED DEAD 12/15/65 11:15 a. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 704 Mt. Holly St.			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 16-02 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 704 Mt. Holly St.		
5. SEX female	6. RACE colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 8/20/65	9. AGE (In years last birthday)	If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min. 4
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Theodore Ford			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
14. MOTHER'S MAIDEN NAME Jeannetta Brown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Theodore Ford 704 Mt. Holly St.		

MEDICAL CERTIFICATION	18. CAUSE OF DEATH Aspiration of stomach contents					INTERVAL BETWEEN ONSET AND DEATH
	(A) DUE TO					
	(B) DUE TO					
	(C) DUE TO					
	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
	19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CAUSING CAUSES OF DEATH? yes
	21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB- UTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
	21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Werner U. Spitz</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Werner U. Spitz, M.D.</u> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12/15/65 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>						
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 12/18/65		23C. NAME of CEMETERY or CREMATORY Mt. Calvary		
24A. DATE REC'D BY HEALTH DEPT. DEC 17 1965		24B. NAME OF REGISTRAR Robert E. Fisher		24C. FUNERAL DIRECTOR Charles A. Rice 661 W. Barre St.		
23D. LOCATION (City, town, or county) Brooklyn, Maryland		23E. (State) Maryland				

WALLINGTON POLICE

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65 12831

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65 12831

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)MAUDDECIE SMITH LEWIS
MANDECIA LEWIS

2. DATE AND HOUR PRONOUNCED DEAD

12/15/65 1:00 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

16-04

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1809 Arunah Ave.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

7/23/09

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Sarah E. Pennington 1913 Walbrook Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/15/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/19/65

23C. NAME of CEMETERY or CREMATORY

Elizabeth Town

23D. LOCATION

(City, town, or county)

(State)

Elizabeth Town, N.C.

24A. DATE REC'D BY HEALTH DEPT.

DEC 17 1965

24B. NAME OF REGISTRAR

Charles A. Rice

24C. FUNERAL DIRECTOR

Charles A. Rice 661 W. Barre St.

ADDRESS

WALTER POORE

BIRTH NO.

65 12832

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 12832

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Lisa FERGUSON Briscoe

2. DATE AND HOUR PRONOUNCED DEAD

Dec. 11, 1965

9:00

P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

728 E. 43rd Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

4-12-1963

9. AGE (In years
last birthday)

2

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Walter E. Briscoe

14. MOTHER'S MAIDEN NAME

Margene Ferguson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

Margene Ferguson 1306 Springfield Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Carbonmonoxyd-poisoning following
smoke and soot-inhalation.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?728 E. 43rd Street, Baltimore21D. TIME
OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

Dec. 11, 1965, 8:40

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

house-fire

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Dec. 12, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-16-65

23C. NAME of CEMETERY or CREMATORY

National Cemetery Balto. Md.

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 17 1965

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Rendell G. Collick 1412 E. Preston St.

ADDRESS

Wm. H. H. H.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 12833

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print) Deborah FERGUSON Briscoe

2. DATE AND HOUR PRONOUNCED DEAD

Dec. 11, 1965 9:10 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

728 E. 43rd Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

11-28-1961

9. AGE (In years
last birthday)

4

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltic. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Walter E. Briscoe

14. MOTHER'S MAIDEN NAME

Margene Ferguson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

NONE

17. INFORMANT

ADDRESS

Margene Ferguson 1206 Springfield Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Carbon monoxide poisoning following
smoke and soot inhalation.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.) home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

728 E. 43rd Street, Baltimore

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

Dec. 11 1965 8:40

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

house-fire

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Dec. 12, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-16-65

23C. NAME OF CEMETERY or CREMATORY

National Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltic. Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 17 1965

24B. NAME OF REGISTRAR

R. J. Collick

24C. FUNERAL DIRECTOR

R. J. Collick

ADDRESS

1412 E. Preston St.

44-04-56

NIW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.

65 12834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 12834

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

THORPE, ROBERT A.

2. DATE AND HOUR OF DEATH

12/11/65

5:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospital
4940 Eastern Avenue, Balto. Md. 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

2206 CECIL AVE

18

5. SEX

M

6. RACE

N

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

9/5/47

9. AGE (In years
last birthday)

18

If Under 1 Yr.
Months: DaysIf Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

STUDENT

10B. KIND OF BUSINESS OR INDUSTRY

School

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ROBERT THORPE

14. MOTHER'S MAIDEN NAME

ANNETTE BRADSHAW

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

219-44-9695

17. INFORMANT RECORDS:

BCH; 4940 Eastern Avenue, Balto. Md. 21224

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

PONTINE HEMORRHAGE

INTERVAL BETWEEN
ONSET AND DEATH

12 hrs

(B) DUE TO

ACUTE BLASTIC LEUKEMIA

7 months

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
WorkNot While
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec 4 19 65 to Dec 11 19 65,
that (I) (we) last saw the deceased alive on Dec 11 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

G.A. POSEN

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

X

23B. DATE SIGNED

Dec 11/65

23C. PHYSICIAN'S
NAME (Type)

G.A. POSEN

M.D.

23D. ADDRESS 4940 Eastern Avenue, Balto. Md. 21224

Balt. City Hospital, Balt. Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Removal

12-15-65

Cedar Grove Cemetery

Roxboro, N.C.

25A. DATE REC'D BY HEALTH DEPT.

DEC 17 1965

25B. NAME OF REGISTRAR

Robert E. Fink

25C. FUNERAL DIRECTOR

Randolph Collick 1412 E. Preston St.

ADDRESS

1922
2222

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1922

1922

BIRTH NO.

65 12833

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 12835

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Jeffrey Ferguson Briscoe

2. DATE AND HOUR PRONOUNCED DEAD

Dec. 11, 1965

9:20

P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

728 E 43rd Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

9-9-1964

9. AGE (In years
last birthday)

1

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Walter E. Briscoe

14. MOTHER'S MAIDEN NAME

Margene Ferguson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None Margene Ferguson 1206 Springfield Ave

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Carbonmonoxyd-poisoning following
smoke and soot-inhalation.(A) ~~XXXXXX~~

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

728 E. 43rd Street, Baltimore

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

Dec. 11, 1965 8:40 P.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

house-fire

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Dec. 12, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county)

(State)

Burial

12-16-65

National Cemetery

Balto.

Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

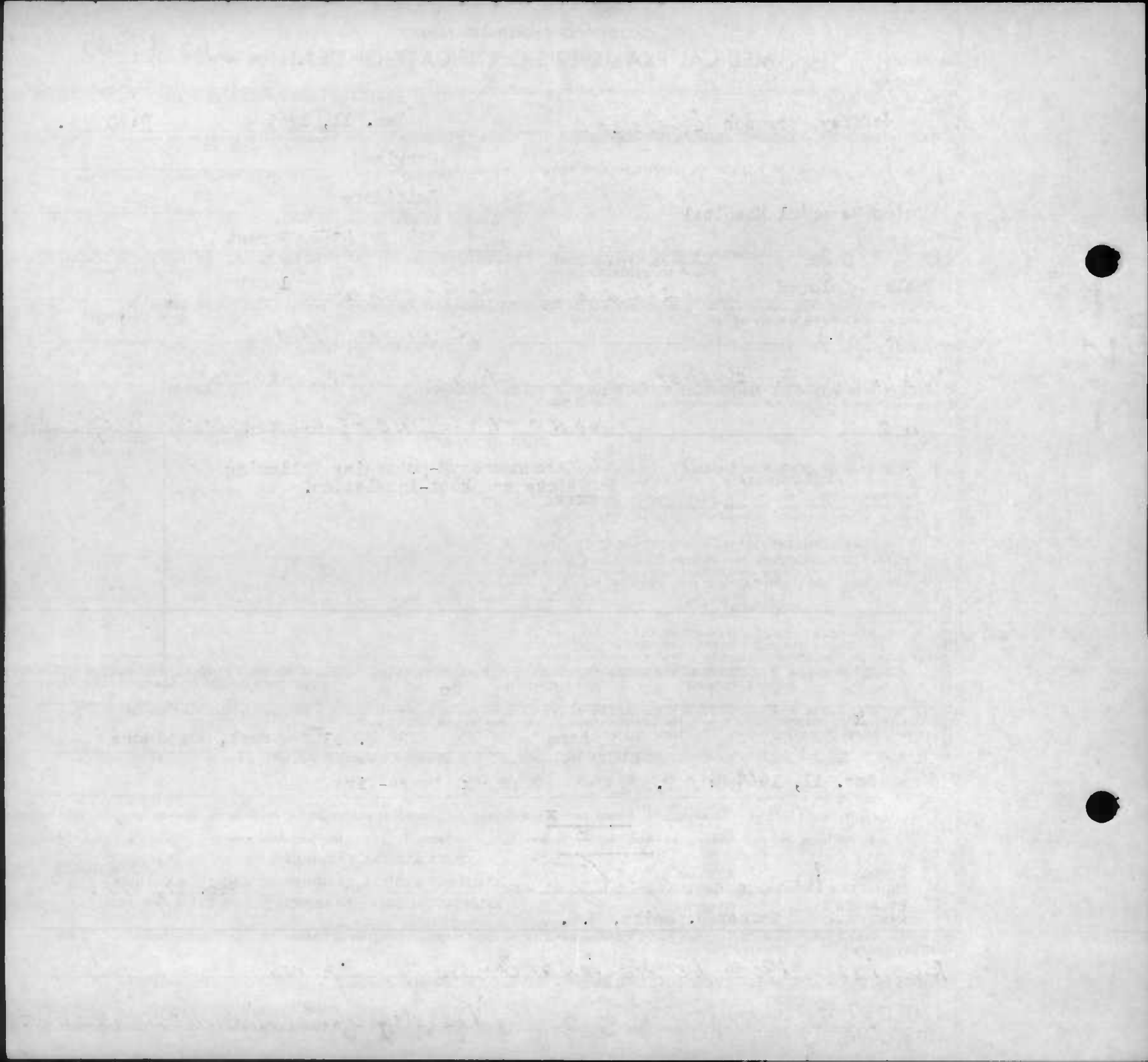
24C. FUNERAL DIRECTOR

ADDRESS

DEC 17 1965

Robert E. Fisher M.D.

Raymond J. Collick 1412 E. Preston St



M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **Terry FERGUSON Sherman** 2. DATE AND HOUR PRONOUNCED DEAD **Dec. 11, 1965 9:10 P.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

728 E. 43rd Street

5. SEX **Male** 6. RACE **Colored** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **single** 8. DATE OF BIRTH **6-2-1960** 9. AGE (In years last birthday) **5**

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **None** 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) **Balto. Md.** 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Frank B. Sherman

14. MOTHER'S MAIDEN NAME

Margene Ferguson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Margene Ferguson 1206 Springfield Ave

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Carbonmonoxyd-poisoning following

burn smoke and soot-inhalation.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) **No** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **home**

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

728 E 43rd Street, Baltimore

21D. TIME OF INJURY (Approx.) **Dec. 11 1965 8:40 P.M.**

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

house-fire

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED **Dec. 12, 1965**

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **12-16-65** 23C. NAME of CEMETERY or CREMATORY **National Cemetery Balto.** 23D. LOCATION (City, town, or county) (State) **Md.**

24A. DATE REC'D BY HEALTH DEPT.

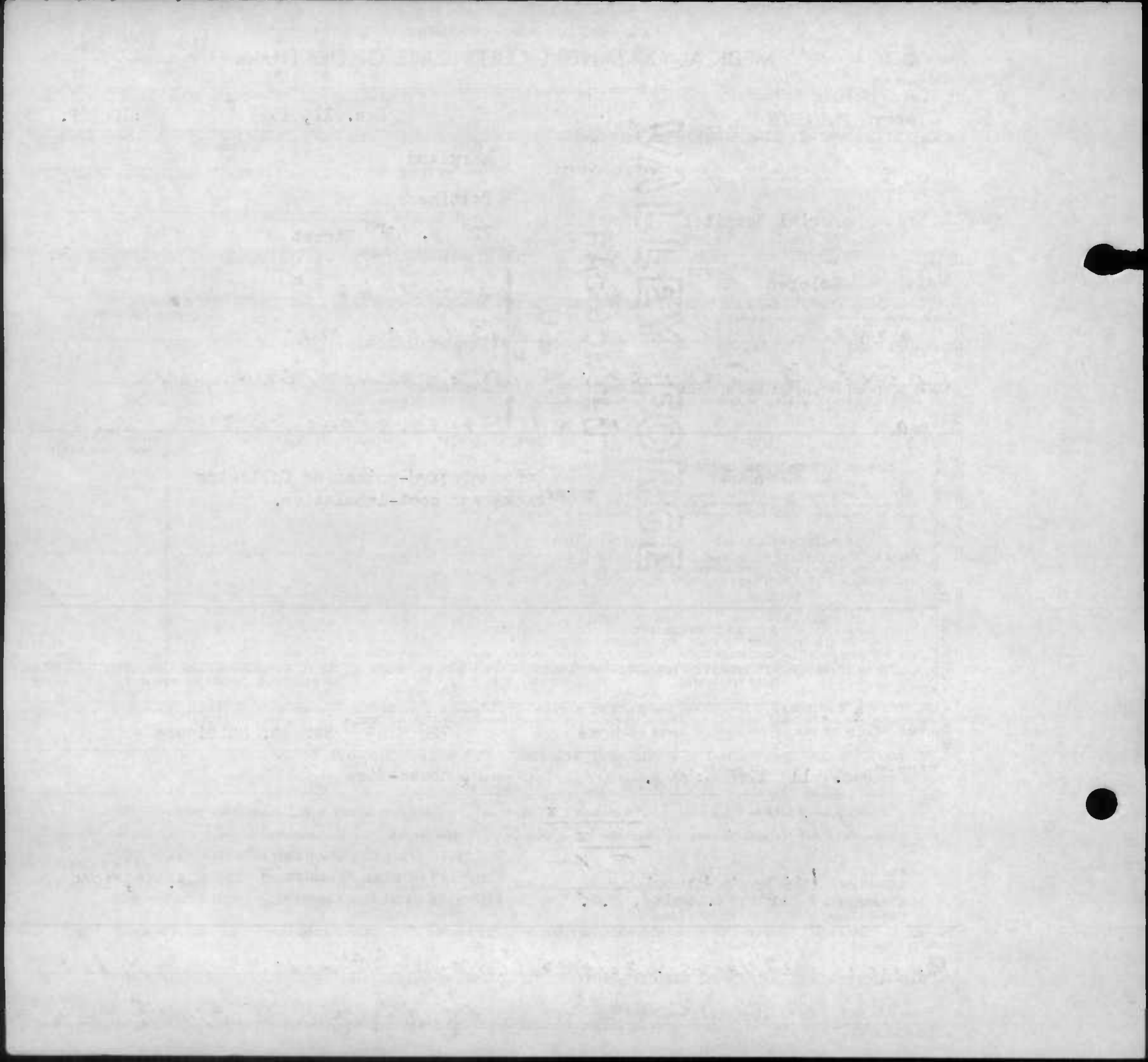
DEC 17 1965

24B. NAME OF REGISTRAR

Robert E. Johnson

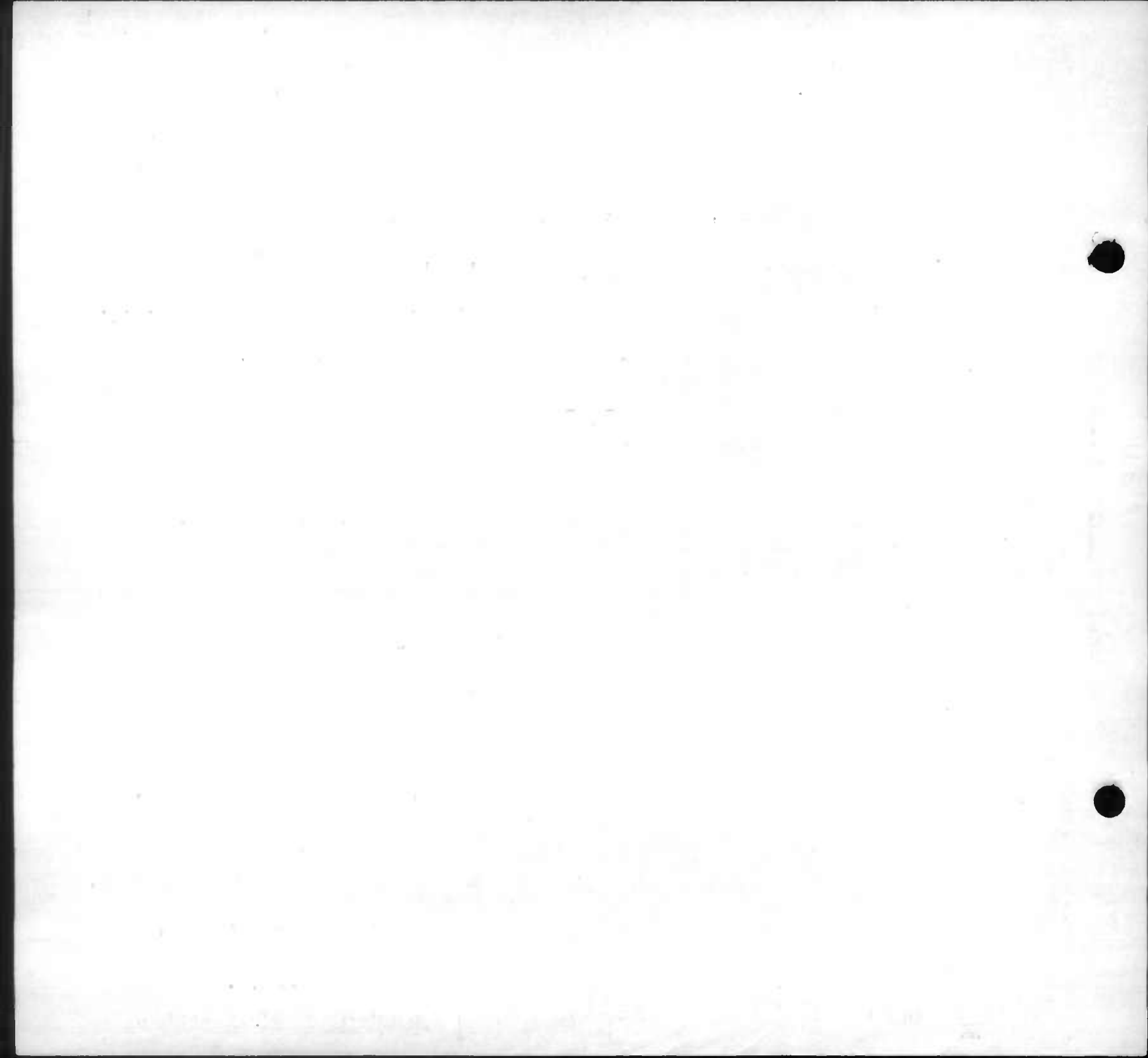
24C. FUNERAL DIRECTOR

Randolph J. Collick 1412 E. Preston St



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p style="font-size: 24pt; margin: 0;">65 12837</p> <p style="font-size: 18pt; margin: 0;">BIRTH NO.</p>		<p style="font-size: 18pt; margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 24pt; margin: 0;">CERTIFICATE OF DEATH</p>		<p style="font-size: 18pt; margin: 0;">Registered No. 65 12837</p>	
<p>M.E. CASE NO.</p>					
<p>1. NAME OF DECEASED (Type or Print)</p> <p style="font-size: 18pt;">Allen J. (Alan) Moore</p>			<p>2. DATE AND HOUR OF DEATH</p> <p style="font-size: 18pt;">December 14, 1965 6:45 a. M.</p>		
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p style="font-size: 12pt;">FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p style="font-size: 18pt;">Provident Hospital 1514 Division Street Baltimore, Maryland 21217</p>			<p>4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)</p> <p style="font-size: 12pt;">A. STATE B. COUNTY</p> <p style="font-size: 18pt;">Maryland</p> <p style="font-size: 12pt;">C. CITY OR TOWN (If outside city limits, write RURAL and give township)</p> <p style="font-size: 18pt;">Baltimore</p> <p style="font-size: 12pt;">D. STREET ADDRESS (If rural, give location)</p> <p style="font-size: 18pt;">1101 Laurens Street</p>		
<p>5. SEX</p> <p style="font-size: 18pt;">Male</p>	<p>6. RACE</p> <p style="font-size: 18pt;">Negro</p>	<p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)</p> <p style="font-size: 18pt;">Married</p>	<p>8. DATE OF BIRTH</p> <p style="font-size: 18pt;">Feb, 22, 1922</p>	<p>9. AGE (In years last birthday)</p> <p style="font-size: 18pt;">43</p>	<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p style="font-size: 18pt;">none</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p style="font-size: 18pt;">none</p>			<p>10B. KIND OF BUSINESS OR INDUSTRY</p> <p style="font-size: 18pt;">none</p>		<p>11. BIRTHPLACE (State or foreign country)</p> <p style="font-size: 18pt;">North Carolina</p>
<p>12. CITIZEN OF WHAT COUNTRY?</p> <p style="font-size: 18pt;">U.S.A.</p>			<p>13. FATHER'S NAME</p> <p style="font-size: 18pt;">Welling J. Moore</p>		
<p>14. MOTHER'S MAIDEN NAME</p> <p style="font-size: 18pt;">Addie L. Moore</p>			<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p style="font-size: 18pt;">Yes WW II</p>		
<p>16. SOCIAL SECURITY NO.</p> <p style="font-size: 18pt;">240-18-0364</p>			<p>17. INFORMANT</p> <p style="font-size: 18pt;">Robert Holton-friend</p>		
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p style="font-size: 18pt;">Delirium tremors</p> <p style="font-size: 12pt;">(This does not mean the mode of dying, e.g., heart failure, atherio, etc. It means the disease, injury or complication which caused death.)</p>			<p>19. ANTECEDENT CAUSES</p> <p style="font-size: 18pt;">Chronic alcoholism with cirrhosis of the liver</p> <p style="font-size: 12pt;">DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		
<p>20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
<p>21A. DATE OF OPERATION</p> <p style="font-size: 18pt;">2</p>		<p>21B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p> <p style="font-size: 18pt;">No</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p> <p style="font-size: 18pt;">(APPROX.)</p>		<p>21E. INJURY OCCURRED</p> <p style="font-size: 18pt;">While At Work</p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from December 4, 1965 to December 14, 1965, that (I) (we) last saw the deceased alive on December 14, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE</p> <p style="font-size: 18pt;">Andre Rigaud</p>			<p>23B. DATE SIGNED</p> <p style="font-size: 18pt;">December 15, 1965</p>		
<p>23C. PHYSICIAN'S NAME (Type)</p> <p style="font-size: 18pt;">Andre Rigaud</p>			<p>23D. ADDRESS</p> <p style="font-size: 18pt;">1514 Division Street-Baltimore, Maryland</p>		
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p style="font-size: 18pt;">Burial</p>		<p>24B. DATE</p> <p style="font-size: 18pt;">12/20/65</p>		<p>24C. NAME of CEMETERY or CREMATORY</p> <p style="font-size: 18pt;">Balto National Cemetery Balto., Md.</p>	
<p>24D. LOCATION (City, town, or county) (State)</p>		<p>25A. DATE REC'D BY HEALTH DEPT.</p> <p style="font-size: 18pt;">DEC 17 1965</p>			
<p>25B. NAME OF REGISTRAR</p> <p style="font-size: 18pt;">Robert E. ...</p>		<p>25C. FUNERAL DIRECTOR</p> <p style="font-size: 18pt;">Wm C. March 928 E. North Ave</p>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 12838		CERTIFICATE OF DEATH		65 12838	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
William Harrison			12/16/65 12:50 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital			A. STATE Maryland		
			B. COUNTY Baltimore		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 423 E 22nd St		
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 4/74	9. AGE (In years last birthday) 91	10. Under 1 Yr. Months: Days Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Harrison			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mrs. Lena Harrison 423 E 22 St		
18. 493X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO pneumonia		INTERVAL BETWEEN ONSET AND DEATH 3 wks
19. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/11/65 to 12/16/65, that (I) (we) lost-saw the deceased alive on 12/16/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hudson Fesche			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/16/1965
23C. PHYSICIAN'S NAME (Type) Hudson Fesche			23D. ADDRESS M.D. UNION MEMORIAL HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/20/65	24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Co.		24D. LOCATION (City, town, or county) (State) Ann Arundel City, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1965		25B. NAME OF REGISTRAR Robert J. Schmitt		25C. FUNERAL DIRECTOR ADDRESS WM. MARSH 928 E. North Ave	

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ASTOR LENOX TILDEN FOUNDATION

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 12839				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 12839	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) NORMA K. WATTS				2. DATE AND HOUR OF DEATH 12-16-65 8:20 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital				A. STATE Maryland B. COUNTY Baltimore			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 116 W. University Parkway			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 11-2-80	9. AGE (In years last birthday) 85	If Under 1 Tr. Months Days Hours Min. If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Watts				14. MOTHER'S MAIDEN NAME Mary Ann Henrietta Wise			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-2365		17. INFORMANT Hospital Records		ADDRESS	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHO PNEUMONIA				4 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				1 year			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 12-15-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED POSSIBLE CHOLECYSTITIS		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 12-6 1965 to 12-16 1965 , that (1) (we) last saw the deceased alive on 12-16 1965 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph D. Schmidt				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-16-65	
23C. PHYSICIAN'S NAME (Type) JOSEPH D. SCHMIDT				23D. ADDRESS 601 N. BROADWAY BALTO, MD 21202			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 18, 1965		24C. NAME of CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1965				25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR Wm. V. Dickner & Sons	
				ADDRESS		W. & P. Aves.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

65 12840		BALTIMORE CITY HEALTH DEPARTMENT		65 12840	
BIRTH NO.		CERTIFICATE OF DEATH		Registered No.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		VIRGINIA LEE DAVIS		12-16-65 5-15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
UNION MEMORIAL HOSPITAL		MD. 27-14			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTO.			
		D. STREET ADDRESS (If rural, give location)			
		211 OAKDALE RD. 2210			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
F	CAUC.	M	2-9-94	71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HS WFE				MD.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Charles H Gibbs		Emily Thompson		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
UNK.				D. Alston Davis S.A.A.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury at complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
260X1		(A) Myocardial Decompensation or Infarction		Hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Cerebral Anoxia and		Hours	
		(C) Diabetes mellitus		Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Hemiplegia (R)			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
Dec 3 1965		Intest. obstruction		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 12-3 1965 to 12-16 1965, that (I) last saw the deceased alive on Dec 16 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE Arthur M. LaBruce Jr.				23B. DATE SIGNED 12-16-65	
23C. PHYSICIAN'S NAME (Type) ARTHUR M. LABRUC, JR.				23D. ADDRESS Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		Dec. 18, 1965		Loudon Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 17 1965		R. E. 500		Wm. A. Pickner & Sons - North Pa. Ave.	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12841 | |
|--|--------------|--|----------------------------|---|---|
| BIRTH NO.
65 12841 | | CERTIFICATE OF DEATH | | Registered No. 65 12841 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Lynwood Ernest Gregory | | 2. DATE AND HOUR OF DEATH
Dec. 5, 1965 12: 50 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
US Public Health Service Hospital
Wyman Pk. Drive & 31st St. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
617 S. Bradford St. | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Div. | 8. DATE OF BIRTH
5/5/95 | 9. AGE (In years last birthday)
70 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Messman | | 10B. KIND OF BUSINESS OR INDUSTRY
Seafarer | | 11. BIRTHPLACE (State or foreign country)
Va. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Richard T. Gregory | | 14. MOTHER'S MAIDEN NAME
Cora Lee | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
578-07-2565 | | 17. INFORMANT ADDRESS
Records- US PHS Hospital, Balto, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) Acute congestive heart failure
DUE TO upper
Massive/gastrointestinal hemorrhage
(B) DUE TO
(C) Nutritional cirrhosis | | INTERVAL BETWEEN ONSET AND DEATH
hours
hours
years | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from Oct. 4, 1965 to Dec. 5, 1965, that (1) (we) last saw the deceased alive on Dec. 5, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
James M. Weaver | | | | 23B. DATE SIGNED
12/13/65 | |
| 23C. PHYSICIAN'S NAME (Type)
James M. Weaver, Medical Director M.D. | | | | 23D. ADDRESS
US PHS Hospital, Balto, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Cremation | | 24B. DATE
12/13/65 | | 24C. NAME of CEMETERY or CREMATORY
Greenmount | |
| 24D. LOCATION
Greenmount Ave & Oliver St.
Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
DEC 17 1965 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Hubbard | | 25C. FUNERAL DIRECTOR
Howard H. Hubbard Funeral Home
4107 Wilkens Ave Balto, Md | | | |

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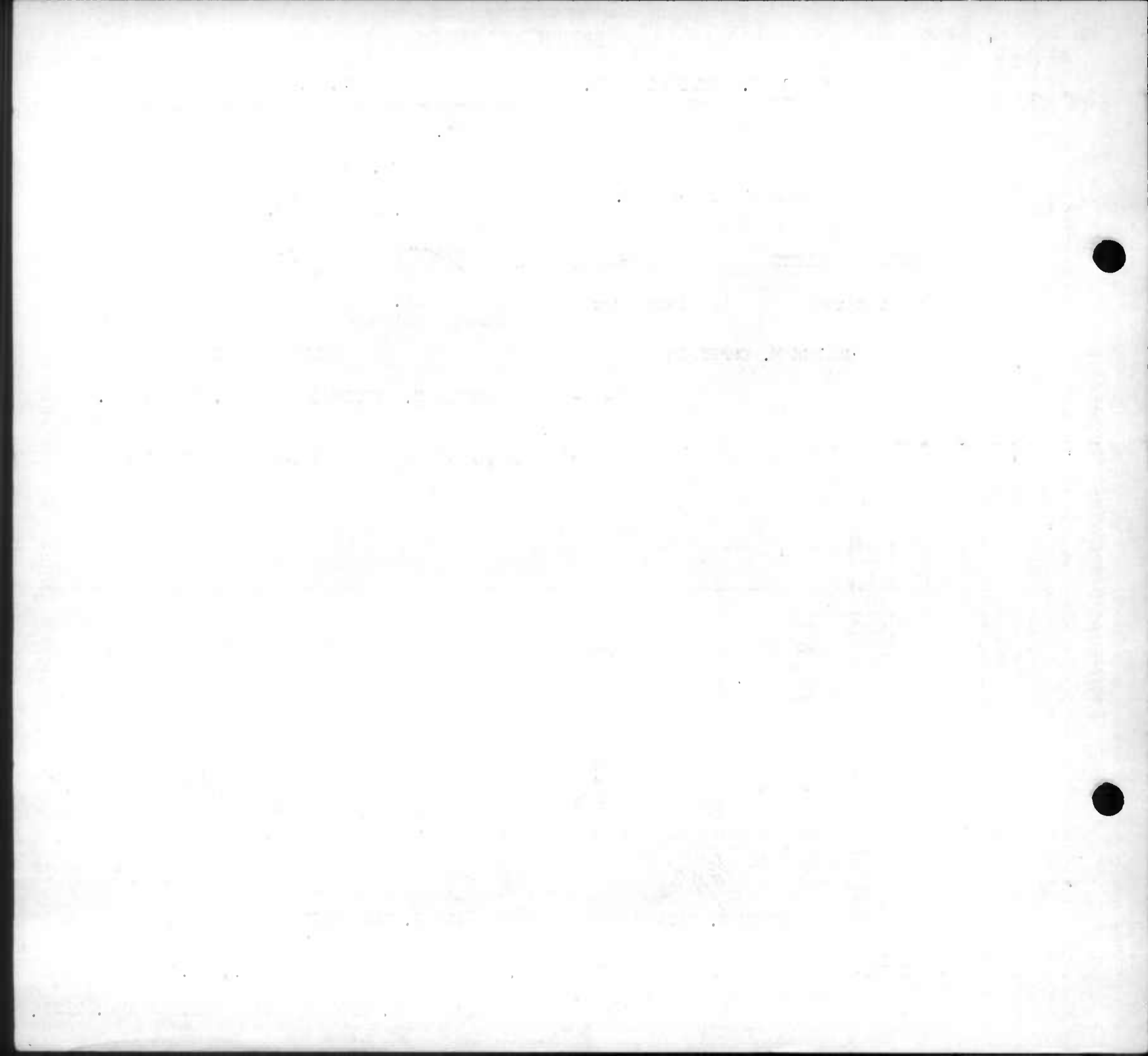
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|---|--|---|
| BIRTH NO. 65 12842 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 12842 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | GEORGE E. CHAPLAIN SR. | | 12.14.65 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

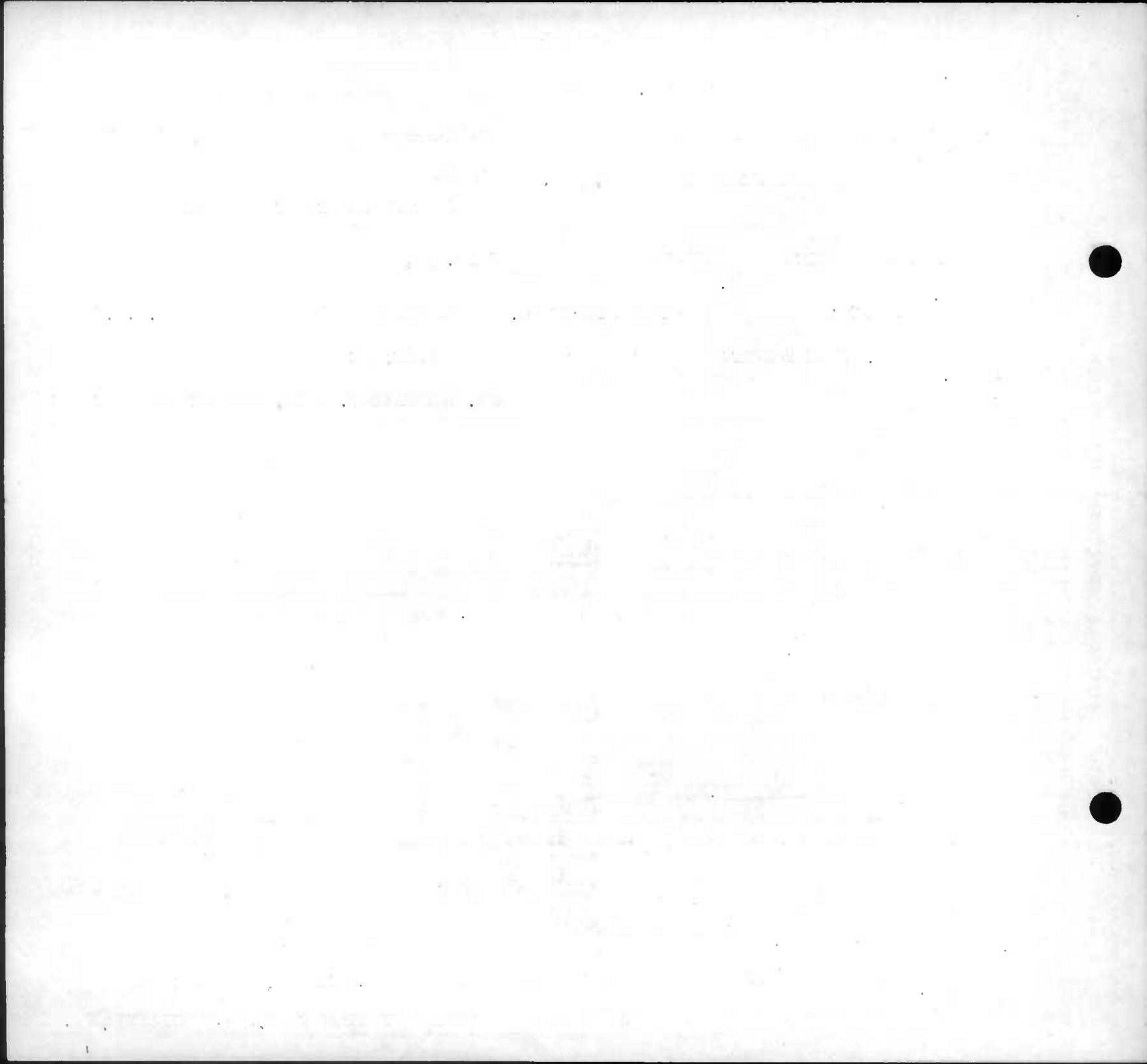
306 S FURROW ST. | | | A. STATE MD. B. COUNTY 2005 | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTO. | | |
| D. STREET ADDRESS (If rural, give location)
306 S. FURROW ST. | | | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
9/19/09 | 9. AGE (In years last birthday)
56 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
retired | | 10B. KIND OF BUSINESS OR INDUSTRY
inspector | | 11. BIRTHPLACE (State or foreign country)
MD. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | |
| 13. FATHER'S NAME
GEORGE M. CHAPLAIN | | | 14. MOTHER'S MAIDEN NAME
HETTIE HARRISON | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
217-20-0720 | | 17. INFORMANT ADDRESS
EMELIA E. CHAPLAIN 306 S. FURROW ST. | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CORONARY THROMBOSIS DUE TO ANTERIOCLEROTIC HEART DISEASE | | | INTERVAL BETWEEN ONSET AND DEATH
6 Wk. | | |
| (A) DUE TO | | | | | |
| (B) DUE TO | | | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/28 1965 to 12/14 1965, that (I) (we) lost saw the deceased alive on 12/3 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE
Irvin B. Kaplan | | | | 23B. DATE SIGNED
12/16/65 | |
| 23C. PHYSICIAN'S NAME (Type)
IRVIN B. KAPLAN | | | | 23D. ADDRESS
129 S. BROADWAY | |
| M.D. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
12/17/65 | | 24C. NAME of CEMETERY or CREMATORY
LOUDON PARK CEM. | |
| | | | | 24D. LOCATION
BALTO., MD. | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 17 1965 | | 25B. NAME OF REGISTRAR
Howard H. Hubbard | | 25C. FUNERAL DIRECTOR ADDRESS
4107 WILKENS AVE. 21229 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 12843 | | | | |
| BIRTH NO. 65 12843 | | | | | DATE AND HOUR OF DEATH
DECEMBER 13, 1965 | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print)
MARGARET A. ROBERTS | | | | | 2. DATE AND HOUR OF DEATH
DECEMBER 13, 1965 | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
4905 STAFFORD STREET, APT. 2 | | | | | A. STATE
MARYLAND | | | | |
| | | | | | B. COUNTY
BALTIMORE | | | | |
| 5. SEX
FEMALE | | | | | 6. RACE
WHITE | | | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
SINGLE | | | | | 8. DATE OF BIRTH
SEPT. 23, 1891 | | | | |
| 9. AGE (In years last birthday)
74 | | | | | 10. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
OPERATOR | | | | | 10B. KIND OF BUSINESS OR INDUSTRY
C & P TELEPHONE CO. | | | | |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | |
| 13. FATHER'S NAME
JOHN ROBERTS | | | | | 14. MOTHER'S MAIDEN NAME
MARGARET | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | | | 16. SOCIAL SECURITY NO. | | | | |
| 17. INFORMANT
MR. REINHARD F. HEIL, 4905 STAFFORD STREET #29 | | | | | ADDRESS | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Coronary Occlusion - Missing | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 min. | | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Carcinoma left breast & lung metastases | | | | | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 21A. DATE OF OPERATION | | | | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | |
| 21C. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21D. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21E. TIME OF INJURY (Month) (Day) (Year) (Hour) | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 21G. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | | | |
| 22. I certify that (I) (the hospital) attended the deceased from 2-7 19 63 to 12-13 19 65 , that (I) (we) last saw the deceased alive on 12-9 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
John F. Schaefer | | | | | 23B. DATE SIGNED
12.15.65 | | | | |
| 23C. PHYSICIAN'S NAME (Type)
JOHN SCHAEFER | | | | | 23D. ADDRESS
401 RANDOM ROAD | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | | | | 24B. DATE
12/XX 16/65 | | | | |
| 24C. NAME OF CEMETERY or CREMATORY
NEW CATHEDRAL CEMETERY | | | | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 17 1965 | | | | | 25B. NAME OF REGISTRAR
Hubbard | | | | |
| 25C. FUNERAL DIRECTOR
HUBBARD FUNERAL HOME, 4107 WILKENS AVE. 21229 | | | | | ADDRESS
9 | | | | |



FUNERAL DIRECTOR: IMPORTANT

Patent of Dr. Robert B. Biddle
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12844 | |
|---|--|--|--|--|--|
| BIRTH NO. 65 12844 | | M.E. CASE NO. | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) BERTHA G. BAKER | | 2. DATE AND HOUR OF DEATH
Dec. 13, 1965 | | 2 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY | | 18-02 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
1141 W. Franklin St | | (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| D. STREET ADDRESS (If rural, give location)
1141 W. Franklin St | | 5. SEX Female | | 6. RACE Colored | |
| 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Divorced | | 8. DATE OF BIRTH
Nov. 29, '92 | | 9. AGE (In years last birthday) 73 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
William Gantt | | 14. MOTHER'S MAIDEN NAME
Liza Adams | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mr. Clayton Gantt 1141 W. Franklin | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
42211
Arteriosclerotic
Hypertensive Cardiovascular
disease | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
unknown | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | (B) DUE TO | |
| (C) DUE TO | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from October 1965 to Dec 1965, that (I) (we) last saw the deceased alive on December 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE
Royston B. Scott M.D. | | 23B. DATE SIGNED
Dec 15, 65 | |
| 23C. PHYSICIAN'S NAME (Type)
ROYSTON B SCOTT | | 23D. ADDRESS
1801 W. Belknap St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12-16-65 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn Cemetery | |
| 24D. LOCATION
Baltimore, Md. | | 24E. NAME OF CEMETERY or CREMATORY | | 24F. LOCATION (City, town, or county) (State) | |
| 25A. DATE RECD BY THE DEPT.
DEC 17 1965 | | 25B. FUNERAL DIRECTOR
(Mrs) Frances A. Hemaley | | 25C. ADDRESS
378 W Biddle St | |

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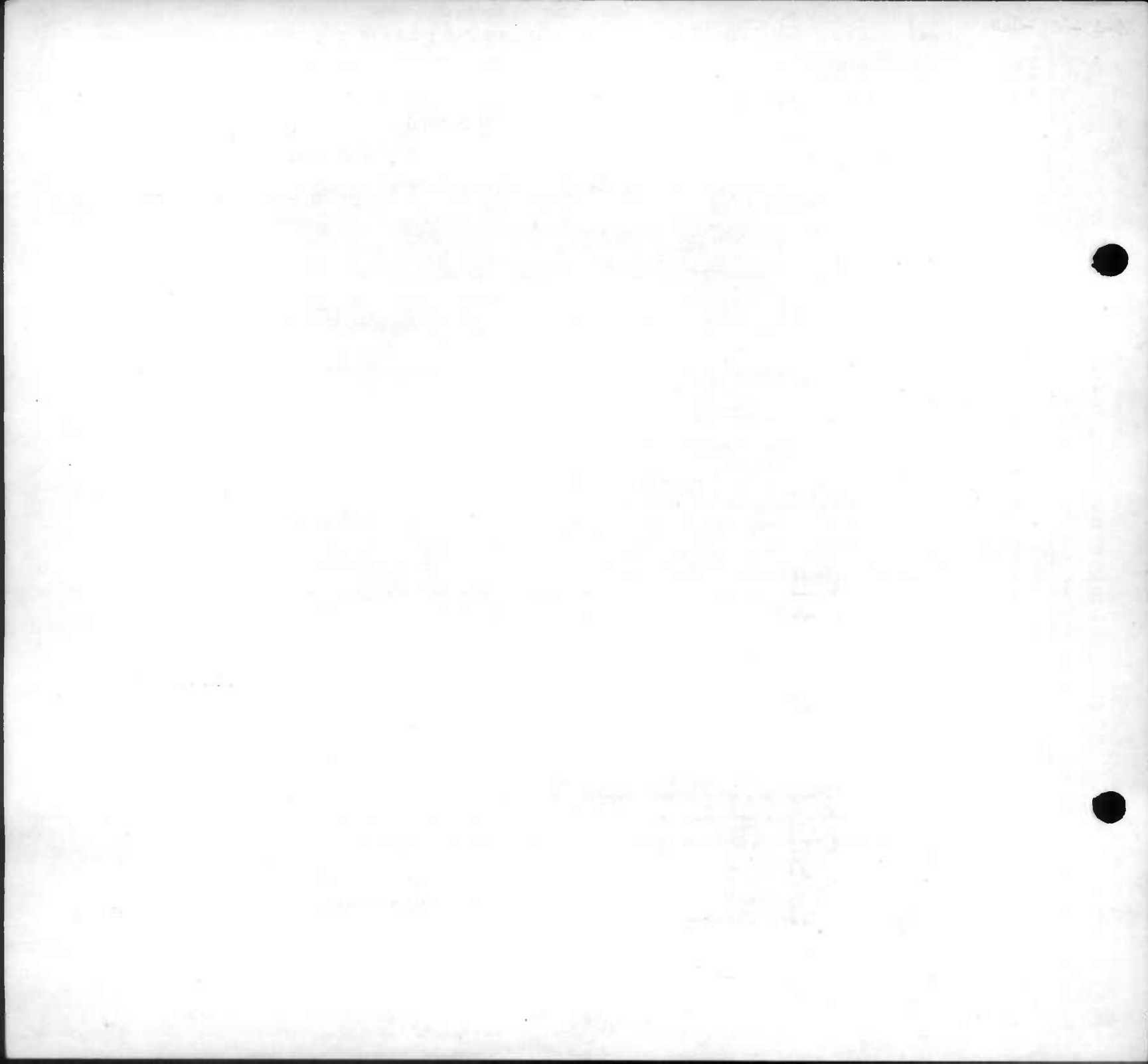
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

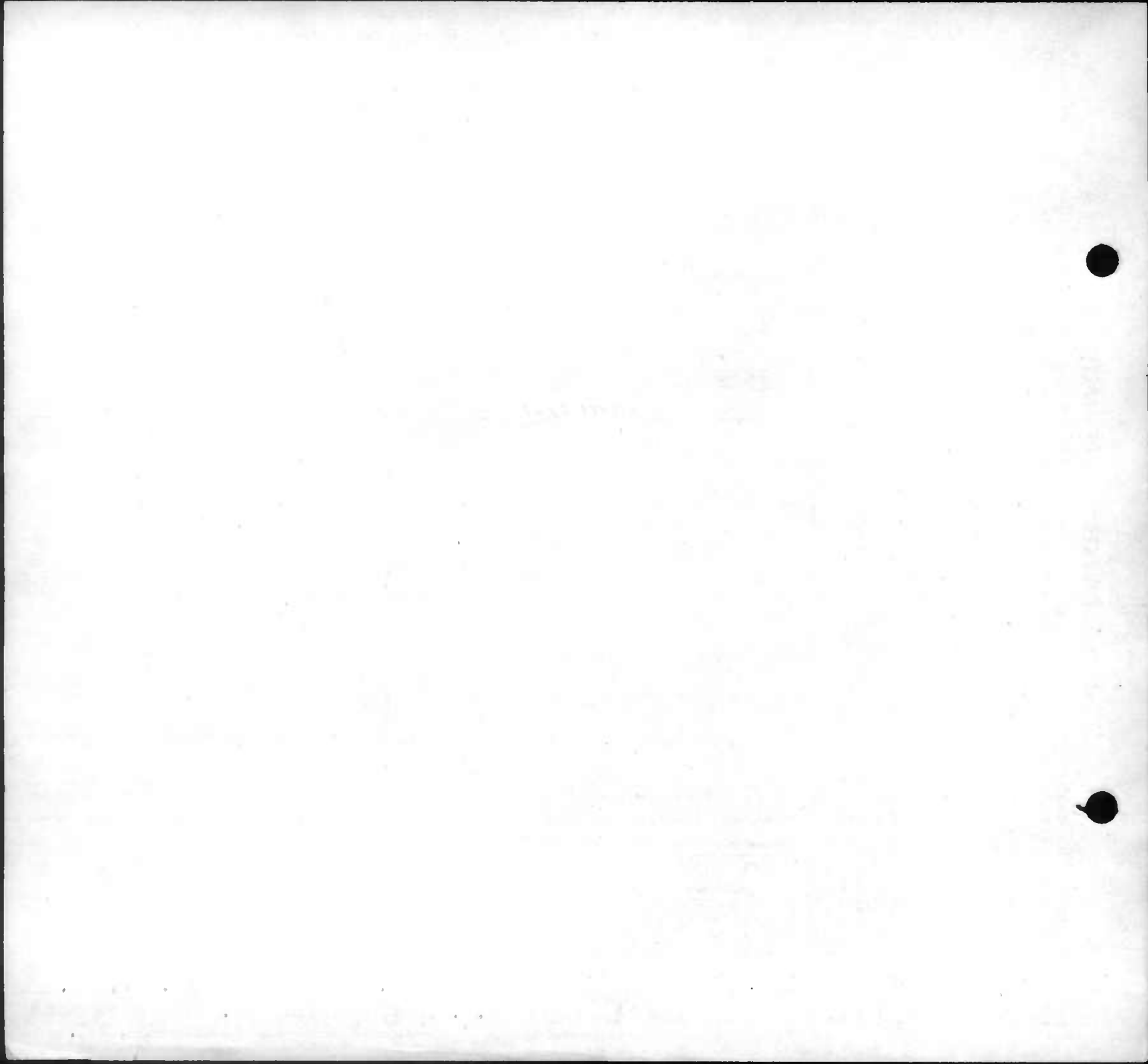
| BIRTH NO. | | M.E. CASE NO. | | NAME OF DECEASED | | DATE AND HOUR OF DEATH | |
|---|--|---------------|--|--|--|------------------------|--|
| 65-30576 | | 45-485-12845 | | BABY GIRL | | 12-13-65 3:25 P.M. | |
| PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| BALTIMORE CITY HOSPITAL | | | | Maryland | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | | CITY OR TOWN | | | |
| BALTIMORE CITY HOSPITAL | | | | Baltimore | | | |
| 5. SEX | | | | 6. RACE | | | |
| Female | | | | Negro | | | |
| 10A. USUAL OCCUPATION | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | |
| None | | | | None | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| None | | | | Rosetta Garry | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? | | | | 16. SOCIAL SECURITY NO. | | | |
| No | | | | | | | |
| 17. INFORMANT | | | | ADDRESS | | | |
| Mother | | | | 2903 Springhill Ave - Balt. Md. | | | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | 8 hrs. 22 min. | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (Congenital). | | | |
| ANTECEDENT CAUSES | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | NONE | | | |
| 19A. DATE OF OPERATION | | | | 20A. AUTOPSY? (Yes or No) | | | |
| Intubation | | | | Yes | | | |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| Respiratory arrest | | | | Yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| No | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED | | | |
| | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 12-13-65 9 AM 19 | | | | | | | |
| that (I) (we) last saw the deceased alive on | | | | | | | |
| 12-13-65 19 | | | | | | | |
| and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Mary C. McLaughlin | | | | 12-13-65 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Mary C. McLaughlin | | | | 4940 Eastern Avenue, Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | | |
| Cremated | | | | 12-15-65 | | | |
| 24C. NAME OF CEMETERY OR CREMATORY | | | | 24D. LOCATION | | | |
| Baltimore City Hospital | | | | Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | |
| DEC 17 1965 | | | | R. E. B. 29 | | | |
| 25C. FUNERAL DIRECTOR | | | | 25D. ADDRESS | | | |
| HOSPITAL DISPOSAL | | | | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|---|---|--|---|
| BIRTH NO.
M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) | | 65 12846
EDWARD F. Bockstie Sr. | | 2. DATE AND HOUR OF DEATH
15-Dec 1965 2:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN
(If outside city limits, write RURAL and give township)
D. STREET ADDRESS
(If rural, give location) | |
| MARYLAND GENERAL Hospital | | | | MARYLAND
BALTIMORE
5610 North wood Drive | |
| 5. SEX
MALE | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
1-12-13 | 9. AGE (In years
last birthday)
52 | If Under 1 Yr.
Months Days
If Under 24 Hrs.
Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY
Allison Equip Co. | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Edward A. Bockstie | | | 14. MOTHER'S MAIDEN NAME
Jessie I. Gousha | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
216-01-7121 | 17. INFORMANT
Previous Admission to Md Gen Hospital by PT. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
163X I
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) DUE TO
PULMONARY EDEMA
(B) DUE TO
CARCINOMA of LUNG, RESECTED
(C) _____ | | | INTERVAL BETWEEN ONSET AND DEATH |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 13-Dec 1965 to 15-Dec 1965 that (we) last saw the deceased alive on 15 Dec 1965 and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
T.C. Culles MD | | | | 23B. DATE SIGNED
15-Dec-65 | |
| 23C. PHYSICIAN'S NAME (Type)
T.C. Culles MD | | | | 23D. ADDRESS
Maryland General Hospital | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12/18/1965 | | 24C. NAME of CEMETERY or CREMATORY
Moreland Memorial Pk. Parkville, Balto. Co., Md. | |
| 24D. LOCATION
(City, town, or county) (State) | | 24E. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. 4905 York Road Baltimore 12, Md. | | | |



C-436

| 65 12847 | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12847 | |
|--|---------|---|------------------|--|---|
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | | | |
| MARY CHILDERS | | 12-13-65 | | 8:53 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE
Maryland | | B. COUNTY | |
| SOUTH BALTIMORE GENERAL HOSPITAL
DOA | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | Baltimore | |
| | | D. STREET ADDRESS (If rural, give location) | | 171 W. Hamburg Street | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years
last birthday) | If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. |
| Female | Colored | | 3-9-1922 | 43 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | SOUTH CAROLINA | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| EDWARD TAYLOR | | SARAH | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | SARAH CHILDERS 171 W. HAMBURG ST | |
| 18. 330X I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) Massive subarachnoid hemorrhage
DUE TO | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) Rupture of congenital aneurysm
of circle of Willis | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21 | | | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 22. | | I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 12-13-65 | |
| RUSSELL S. FISHER, M.D. | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME of CEMETERY or CREMATORY | |
| REMOVAL | | 12-17-65 | | SUMMERTON | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR ADDRESS | |
| DEC 17 1965 | | P. L. S. 2, 3, 4, 5, 6 | | I. L. BROWN & SON 123 W. MONTGOMERY ST | |

WALLLEY FORD

1
M-532

65 12848

BALTIMORE CITY HEALTH DEPARTMENT

65 12848

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

ROBERT MONTAGUE

2. DATE AND HOUR PRONOUNCED DEAD

12/15/65 1:30 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION
2-16-66

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3901 E. Lombard St.

3901 E. Lombard St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

JAN 6, 1889

9. AGE (In years
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

BUSINESSMAN

10B. KIND OF BUSINESS OR INDUSTRY

RETIRED

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

EUGENE VICTOR

14. MOTHER'S MAIDEN NAME

MARY ELLEN COLEMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

YES WW I

16. SOCIAL
SECURITY NO.

215-016756

17. INFORMANT,

Mrs ELIZABETH CLEMENTS

ADDRESS

4135. 16th
HARRISBURG PA

18.

E976X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Gunshot wound of head

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Partial Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRI-
BUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

3901 E. Lombard St.

21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

12 ? 65 ?

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

shot self in head

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/15/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

Dec 20/1965

23C. NAME of CEMETERY or CREMATORY

Louisa National Cem

23D. LOCATION

Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 17 1965

24B. NAME OF REGISTRAR

Robert E. Johnson

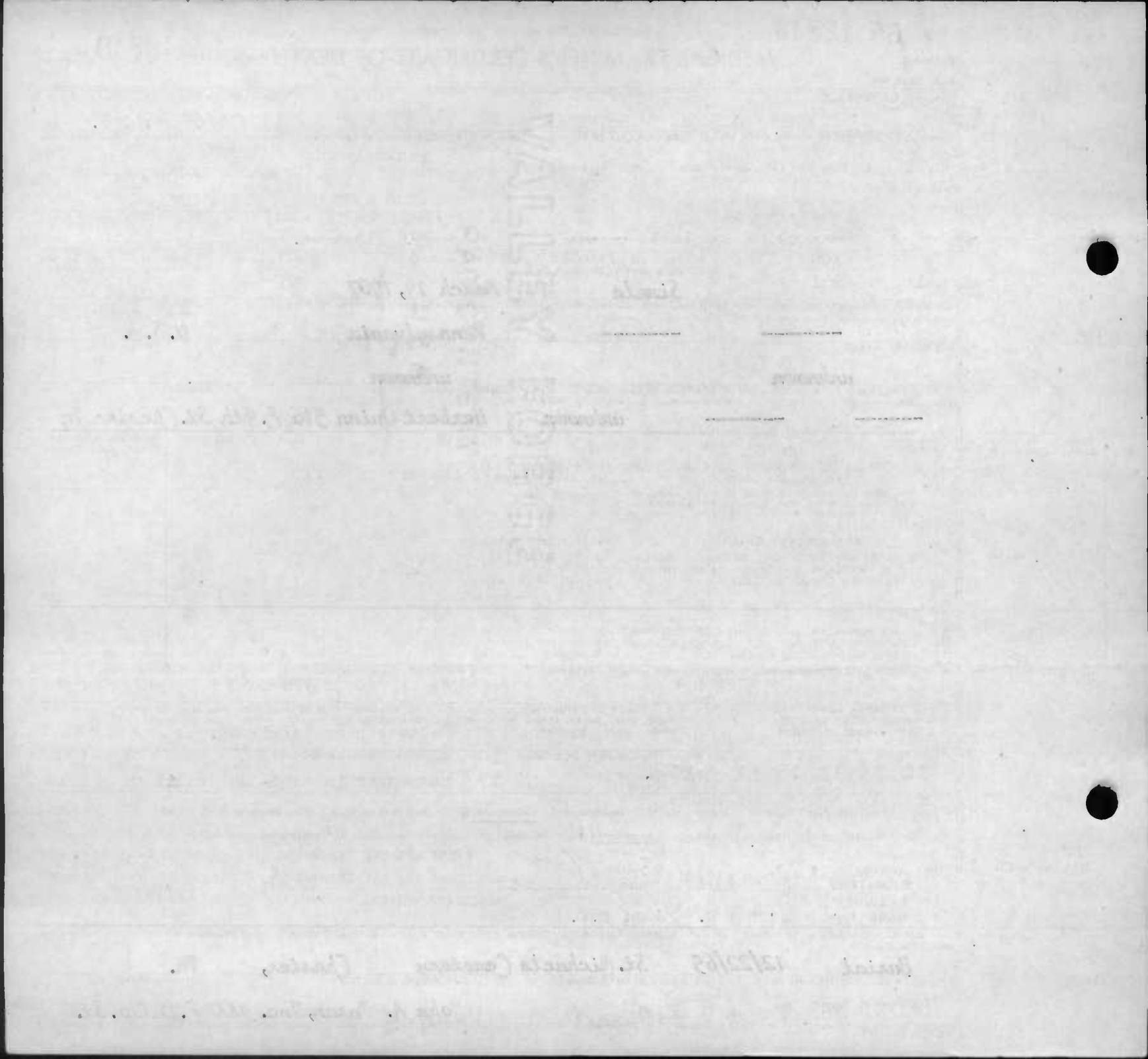
24C. FUNERAL DIRECTOR

Joseph X. Johnson

ADDRESS

2635 Conkling
Baltimore

VALLEY FORCE



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---|---|--|--|---|
| BIRTH NO. 65 12850 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 65 12850 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Agnes C. Myers | | 2. DATE AND HOUR OF DEATH
December 17, 1965 10:30 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 26-08 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION
3519 Claremont Avenue | | D. STREET ADDRESS (If rural, give location)
3519 Claremont Avenue | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
Married | 8. DATE OF BIRTH
6/11/1902 | 9. AGE (In years last birthday)
63 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
James Hales | | 14. MOTHER'S MAIDEN NAME
Christina ? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
219-30-4893 | | 17. INFORMANT ADDRESS
Mr. Earl F. Myers 3519 Claremont Ave. | |
| 18. 443X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, oshtemia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
Hypertensive Cardio-vascular disease
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 1960 to 12/17 1965, that (I) (we) last saw the deceased alive on 12/14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Joseph R. Liberto | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
12/18/65 | |
| 23C. PHYSICIAN'S NAME (Type)
JOSEPH R. LIBERTO | | 23D. ADDRESS
3508 BANK ST. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12/20/1965 | | 24C. NAME OF CEMETERY or CREMATORY
Holy Redeemer Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | | |
| 25B. NAME OF REGISTRAR
John A. Moran Inc. | | 25C. FUNERAL DIRECTOR ADDRESS
3000 E. Baltimore St. | | | |

THE UNIVERSITY OF CHICAGO
DIVISION OF THE PHYSICAL SCIENCES
DEPARTMENT OF CHEMISTRY

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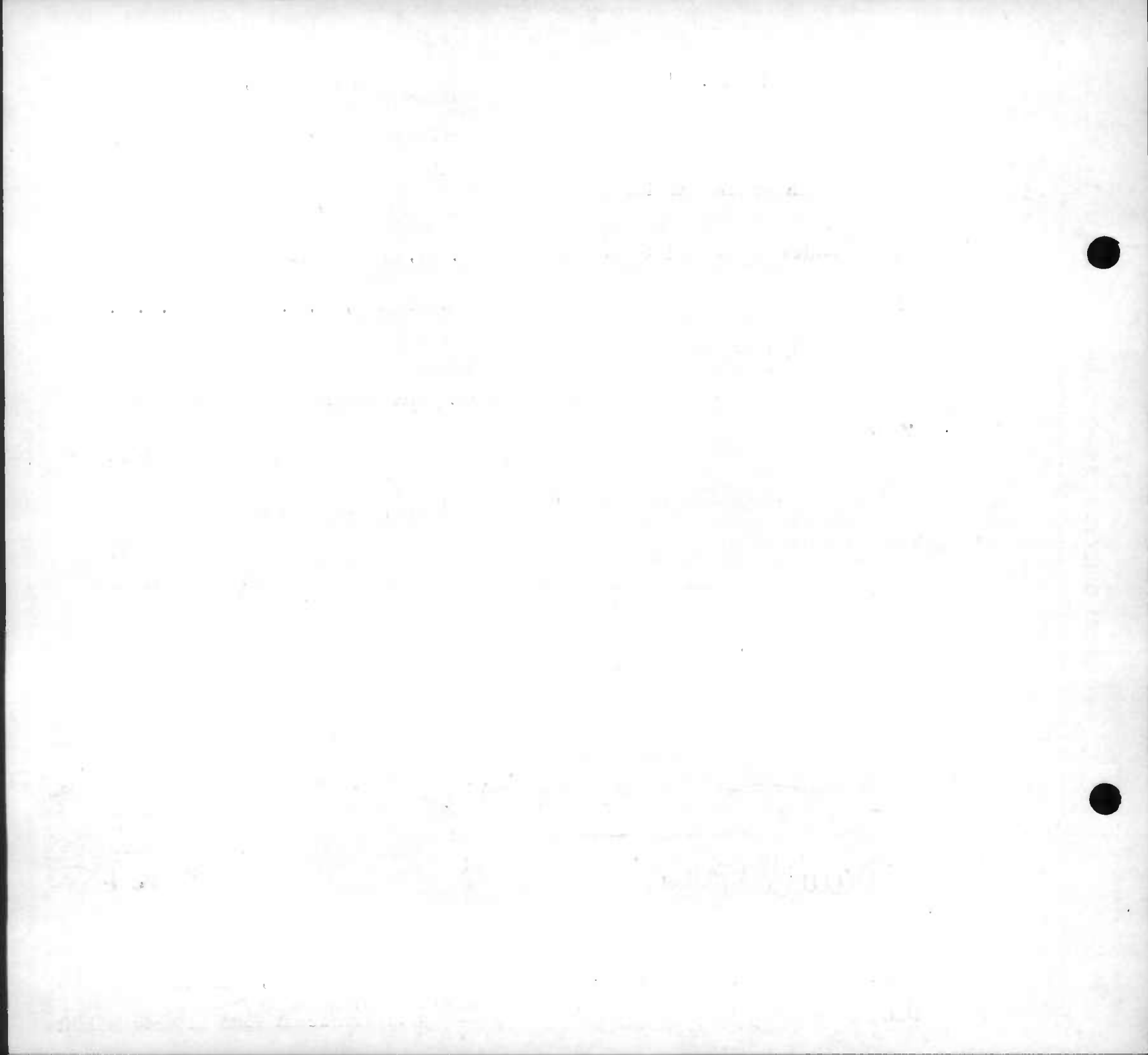
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63

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 12851 | |
|--|---------|--|-------------------------|---|--|--|------------------------------|----------------------------------|--------------------------|
| M.E. CASE NO. 65 12851 | | | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| | | | | Louise M. O'Neill | | December 18, 1965 M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | | | |
| 90 Anderson Nursing Home | | | | Maryland Baltimore | | | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | |
| | | | | Baltimore | | 28-41 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | | | |
| | | | | 4303 Elderon Avenue | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
| Female | White | Widowed | Aug. 27, 1870 | 95 | At Home | Washington, D.C. | U.S.A. | Rudolph Green | Vonhuneiber |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| NO | | | None | | Mrs. Anita Smith 4303 Elderon Avenue | | | | |
| 18. 4 2 0 0 0 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) Atherosclerotic Heart Dis | | | | Years | |
| | | | | (B) Gen. Atherosclerosis | | | | | |
| | | | | (C) | | | | | |
| ANTECEDENT CAUSES | | | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | No | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 1965 to Dec 1965, that (I) (we) last saw the deceased alive on Dec 17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Daniel Galcal | | | | | | | | 23B. DATE SIGNED 12-18-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| | | | | M.D. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 12/20/65 | | Loudon Park Cemetery | | Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| DEC 20 1965 | | Robert J. Galcal | | Elsworth Armacost | | Elsworth Armacost 4600 Liberty Heights | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 65 12852 | |
|--|------------------|--|--|--|--|---|--|
| BIRTH NO. 65 12852 | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | Anne Gustafson | | December 16, 1965 10:50 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

2338 N. Monroe Street | | | | A. STATE
Maryland | | | |
| | | | | B. COUNTY
Baltimore | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
2338 N. Monroe Street | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | | 8. DATE OF BIRTH
9/13/1860 | 9. AGE (In years last birthday)
105 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
At Home | |
| | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Ireland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Michael Daley | | | | 14. MOTHER'S MAIDEN NAME
Cusick | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
XX No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Helen Gustafson 2338 N. Monroe Street | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) <i>Arteriosclerotic C-V. Disease</i>
DUE TO
(B) <i>Generalized Arteriosclerosis</i>
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
<i>years</i>
<i>years</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jan 50</i> to <i>16 Dec 1965</i> , that (I) (we) last saw the deceased alive on <i>14 Dec 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Lauriston L. Keown M.D.</i> | | | | 23B. DATE SIGNED
<i>17 Dec 65</i> | | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Lauriston L. Keown</i> | | | | 23D. ADDRESS
<i>1938 Linden Ave Baltimore Md</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12/18/65 | | 24C. NAME OF CEMETERY or CREMATORY
New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland 21217 | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 25B. NAME OF REGISTRAR
<i>Ellsworth Armacost</i> | | 25C. FUNERAL DIRECTOR
<i>Ellsworth Armacost</i> ADDRESS
4600 Liberty Heights | | | |

Handwritten text, possibly a signature or name, appearing upside down.

Handwritten text at the bottom of the page, including the words "Kaiserlich" and "Königlich".

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|------------------|---|---|---------------------------------------|---|--|--|--|--|
| BIRTH NO. 65 12853 | | | | | CERTIFICATE OF DEATH | | | Registered No. 65 12853 | |
| M.E. CASE NO. | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| 1. NAME OF DECEASED
(Type or Print) Annie S. Stephens | | | | | December 17, 1965 M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Anderson Nursing Home | | | | | A. STATE B. COUNTY
Maryland Baltimore 16-05 | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
2516 W. Lafayette Avenue | | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
1/4/1879 | 9. AGE (In years last birthday)
86 | If Under 1 Yr. Months: Days: Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
At Home | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Jeremiah Weatherby | | | | | 14. MOTHER'S MAIDEN NAME
Sinn | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT ADDRESS
Davis T. Weatherby Timonium, Md. 110 Oakway Road | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
491X I
Bronchopneumonia | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 wk | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 1 19 50 to Dec 17 19 65, that (I) (we) last saw the deceased alive on Dec 17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
J Mendel's M.D. | | | | | 23B. DATE SIGNED
12/17/65 | | | | |
| 23C. PHYSICIAN'S NAME (Type)
C. J. Mendel's M.D. | | | | | 23D. ADDRESS
2308 Edmondson Ave | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | 24B. DATE
12/20/65 | | 24C. NAME OF CEMETERY or CREMATORY
Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | | 25B. NAME OF REGISTRAR
Elisworth Armaoost | | | 25C. FUNERAL DIRECTOR ADDRESS
Elisworth Armaoost 4600 Liberty Heights | | | |

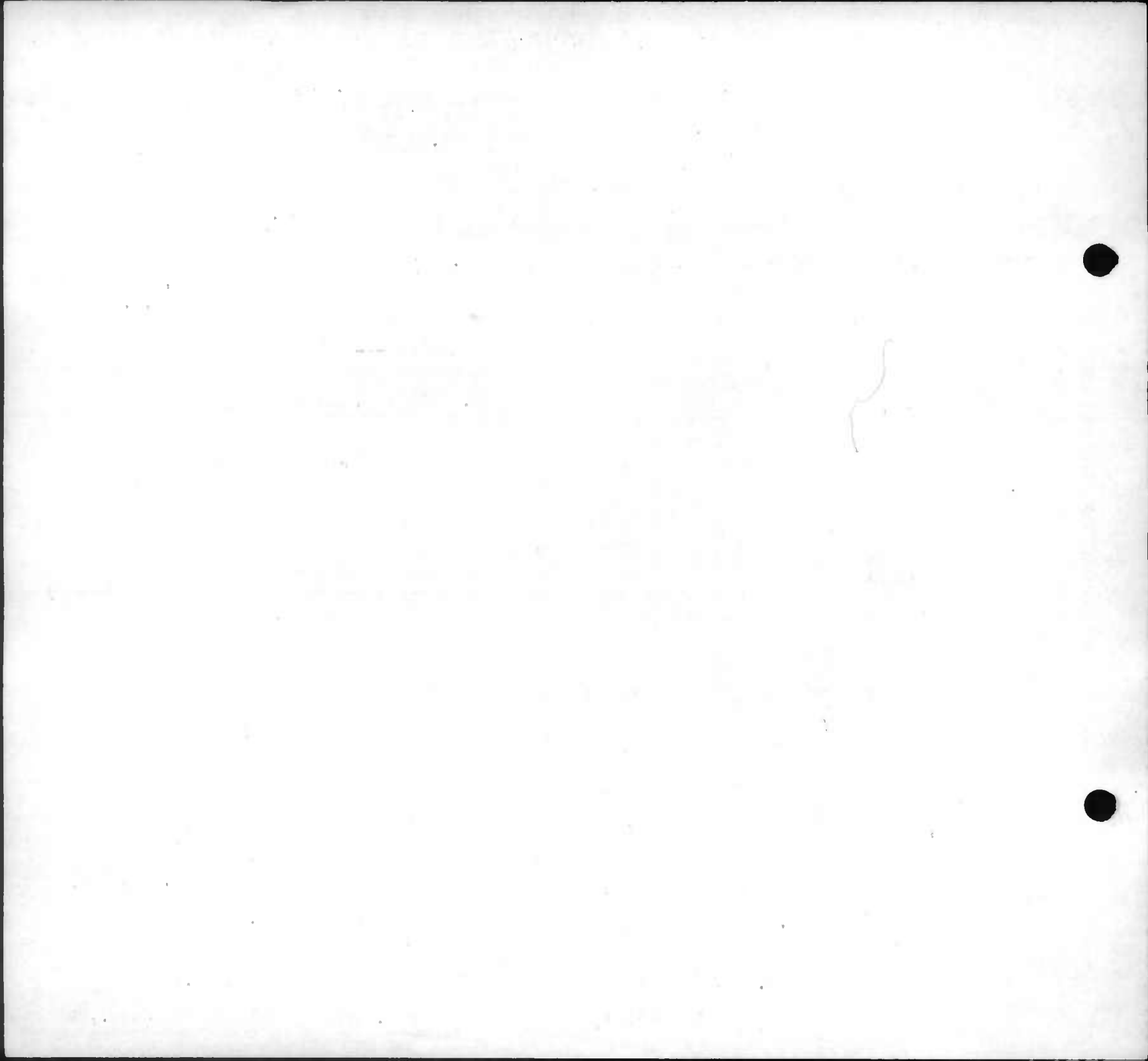
Boone's agreement

Dec 11 at Dec 11
C. J. Wentzel's
2308 Edmondson Ave
12/15/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

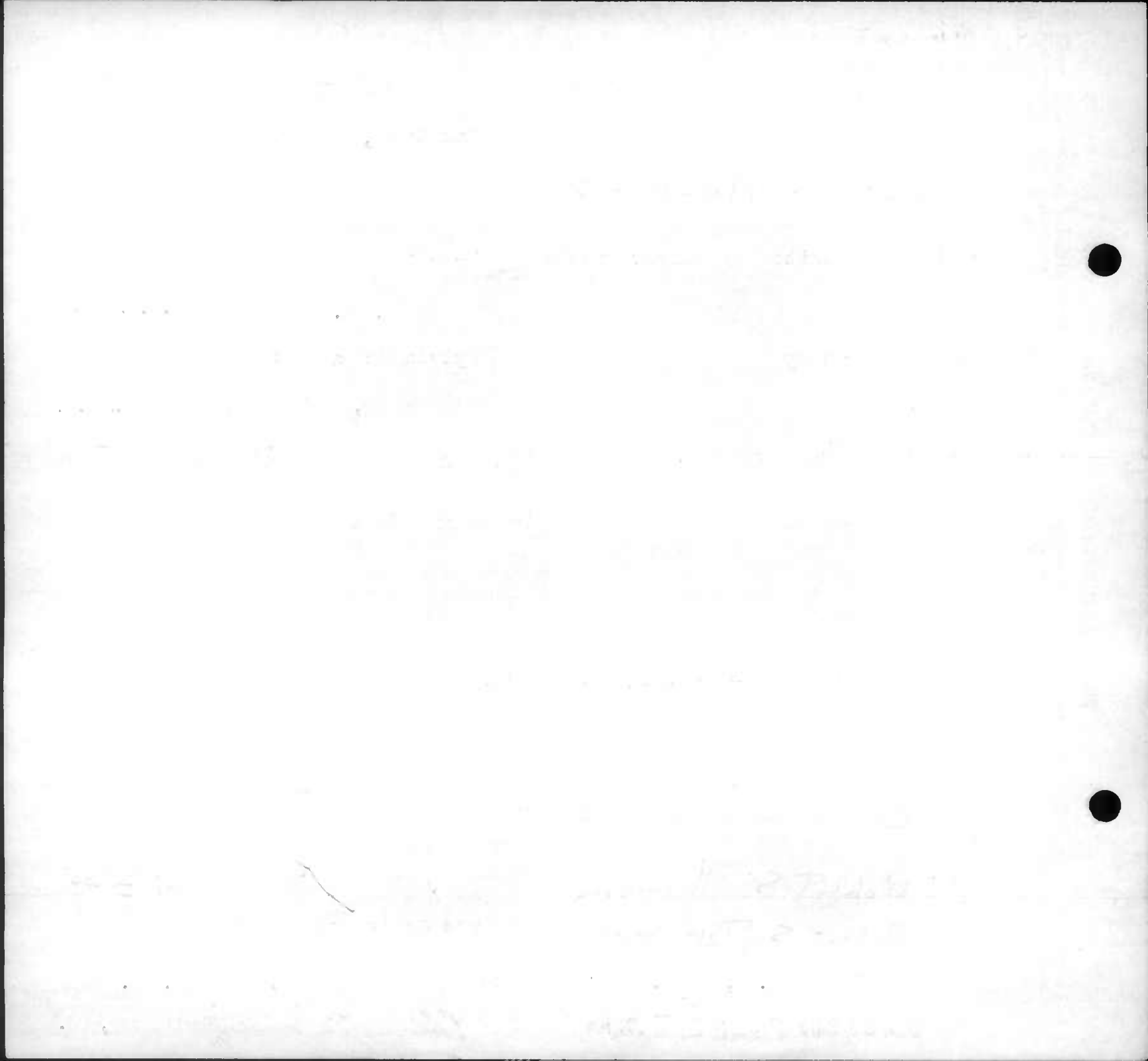
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|---------|--|------------------|--|--|
| 65 12854 | | CERTIFICATE OF DEATH | | 65 12854 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | BESSIE ASHCROFT | | Dec. 14, 1965 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE | | B. COUNTY | |
| South Baltimore General Hospital | | Md. | | 25-05 | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| | | D. STREET ADDRESS (If rural, give location) | | 4120 West Bay Ct. | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| Female | White | Married | Nov. 5, 1892 | 73 | Housewife |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Pennsylvania | | U.S. | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| John Orris | | Louise --- | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | Mr. William Ashcroft (same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | Acute coronary occlusion, immediate | |
| ANTECEDENT CAUSES | | (B) DUE TO | | Coronary atherosclerosis | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) _____ | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | none | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb. 9, 1948 to Dec. 13, 1965, that (I) (we) last saw the deceased alive on Dec. 13, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Dr. Imre Neubauer | | | | Dec. 14, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Dr. Imre Neubauer | | | | 936 Patapsco Ave. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | Dec. 17, '65 | | Glen Haven Memorial Park | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| DEC 20 1965 | | George J. Gofce | | 4001 Ritchie Hwy., Baltimore | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | Registered No. <u>65 12855</u> | |
|--|-------------------------|---|--|--|---|--|---|
| BIRTH NO. <u>Gettysburg, Pa. 65 12855</u> | | | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Lori Ridenour</u> | | | | 12/15/65 5:30 AM M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>JOHNS HOPKINS</u> | | | | A. STATE
<u>Maryland, Frederick</u> | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Emmitsburg</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<u>RD #2</u> | | | |
| 5. SEX
<u>female</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Never married</u> | 8. DATE OF BIRTH
<u>7-6-65</u> | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months: Days | 11. Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Gettysburg, Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 13. FATHER'S NAME
<u>Guy Ridenour</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Sylvia McGloughlin</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
<u>Guy Ridenour, Emmitsburg, Maryland</u> | | |
| | | | | | ADDRESS
<u>R.D. 2</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>752X1</u> | | | | CAUSE OF DEATH
(A) <u>RESPIRATORY ARREST</u>
DUE TO
(B) <u>Hydrocephalus</u>
DUE TO
(C) <u>Birth</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>30 minutes</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<u>3/11/23</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Hydrocephalus</u> | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10/11</u> 19 <u>65</u> to <u>12/15</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12/15</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Robert S. Thompson</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>12/15/65</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>ROBERT S. THOMPSON</u> | | | | 23D. ADDRESS
M.D. <u>The Johns Hopkins Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>Dec. 17, 65</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>St. Mary's Catholic</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Fairfield, Adams Co. Pa.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>DEC 20 1965</u> | | 25B. NAME OF REGISTRAR
<u>Robert S. Thompson</u> | | 25C. FUNERAL DIRECTOR
<u>Charles E. Wilson</u> | | | |
| | | | | ADDRESS
<u>Emmitsburg, Md.</u> | | | |



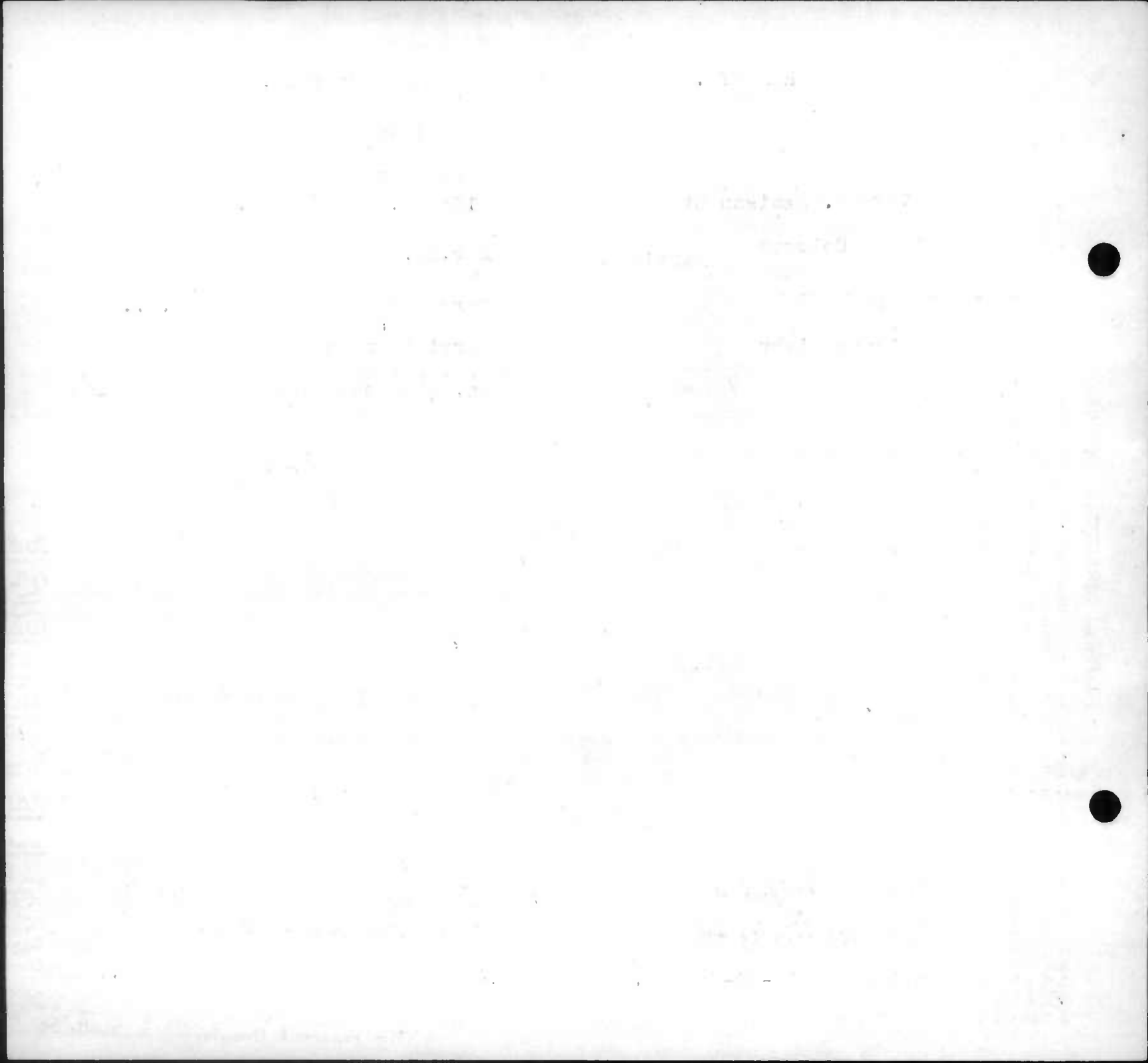
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------------|---|--|--|---|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>65 12856</u> | | | | |
| BIRTH NO.
<u>65 12856</u> | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | | | | | |
| ROBERT . LISBY | | December 16, 1965 | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

1639 E. Madison St | | | | | A. STATE
Maryland | | | | |
| (If not in hospital or institution, give street address or location) | | | | | B. COUNTY | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | |
| | | | | | Baltimore | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) | | | | |
| | | | | | 1639 E. Madison St. | | | | |
| 5. SEX
Male | 6. RACE
Colored | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | | 8. DATE OF BIRTH
Mar. 14, 1890 | 9. AGE (In years last birthday)
75 | If Under 1 Yr.
Months: Days | | If Under 24 Hrs.
Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 13. FATHER'S NAME
Soloman Lisby | | | | 14. MOTHER'S MAIDEN NAME
Harriet Brown | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Mrs. Florence Lusby 1639 E. Madison | | | |
| 18. <u>4 20.0 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)

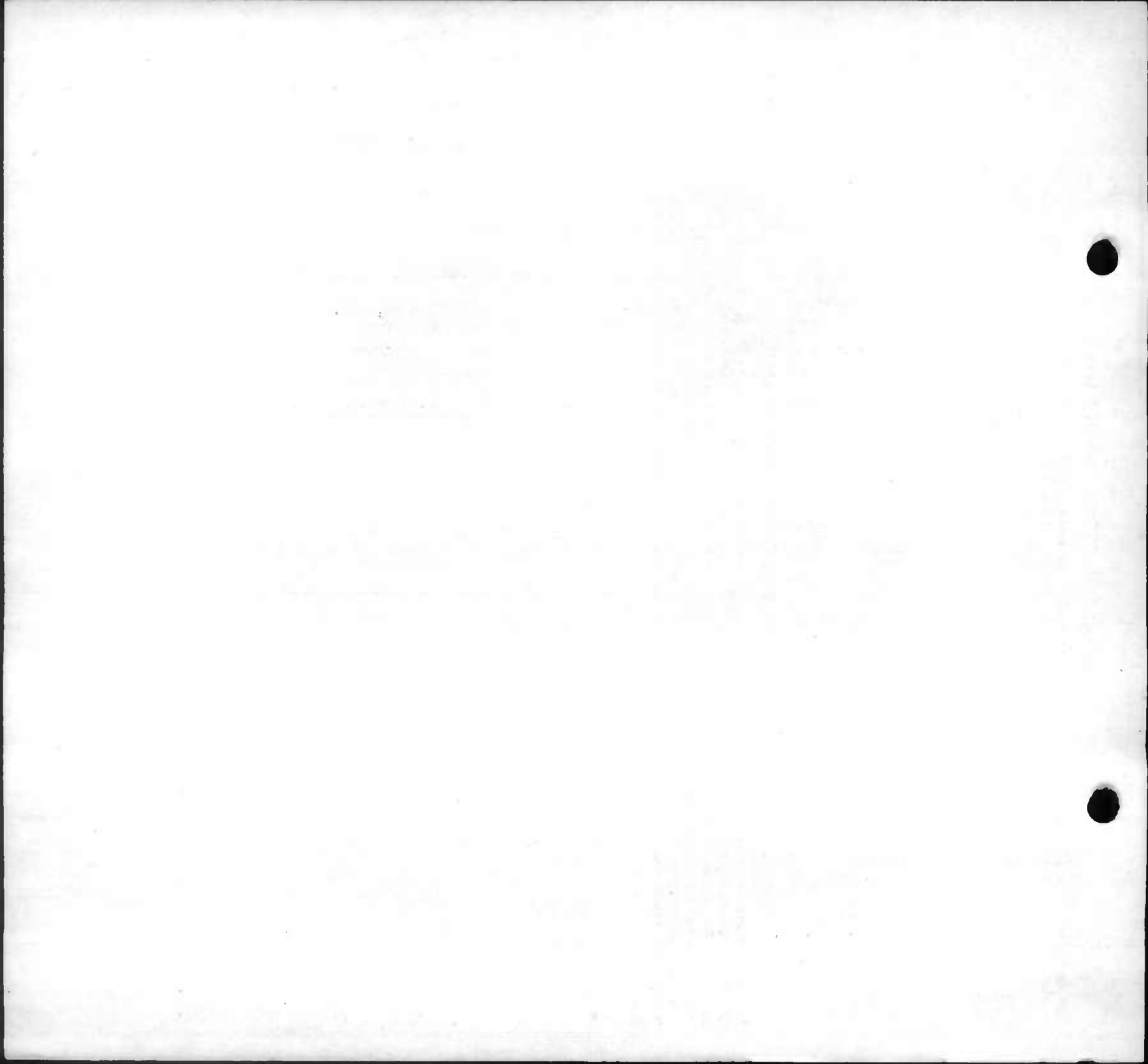
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) <u>Cerebral Heart Disease</u>
DUE TO
(B) _____
DUE TO
(C) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>6/4</u> 19 <u>65</u> to <u>12/16</u> 19 <u>65</u> , that (I) (we) lost saw the deceased olive on <u>12/15</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<i>Emerson R. Julian</i> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED
<u>12/17/65</u> | |
| 23C. PHYSICIAN'S NAME (Type)
EMERSON R. JULIAN | | | | 23D. ADDRESS
M.D. 2379 ARUNAH AVE | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12-20-65 | | 24C. NAME of CEMETERY or CREMATORY
Mt. Zion Cemetery | | 24D. LOCATION (City, town, or county) (State)
Mountain, Harford Co., Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 25B. NAME OF REGISTRAR
<i>John A. Jones</i> | | 25C. FUNERAL DIRECTOR
<i>Mrs. Frances A. Hemmley</i> | | ADDRESS
718 W. Biddle St. Biddle St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

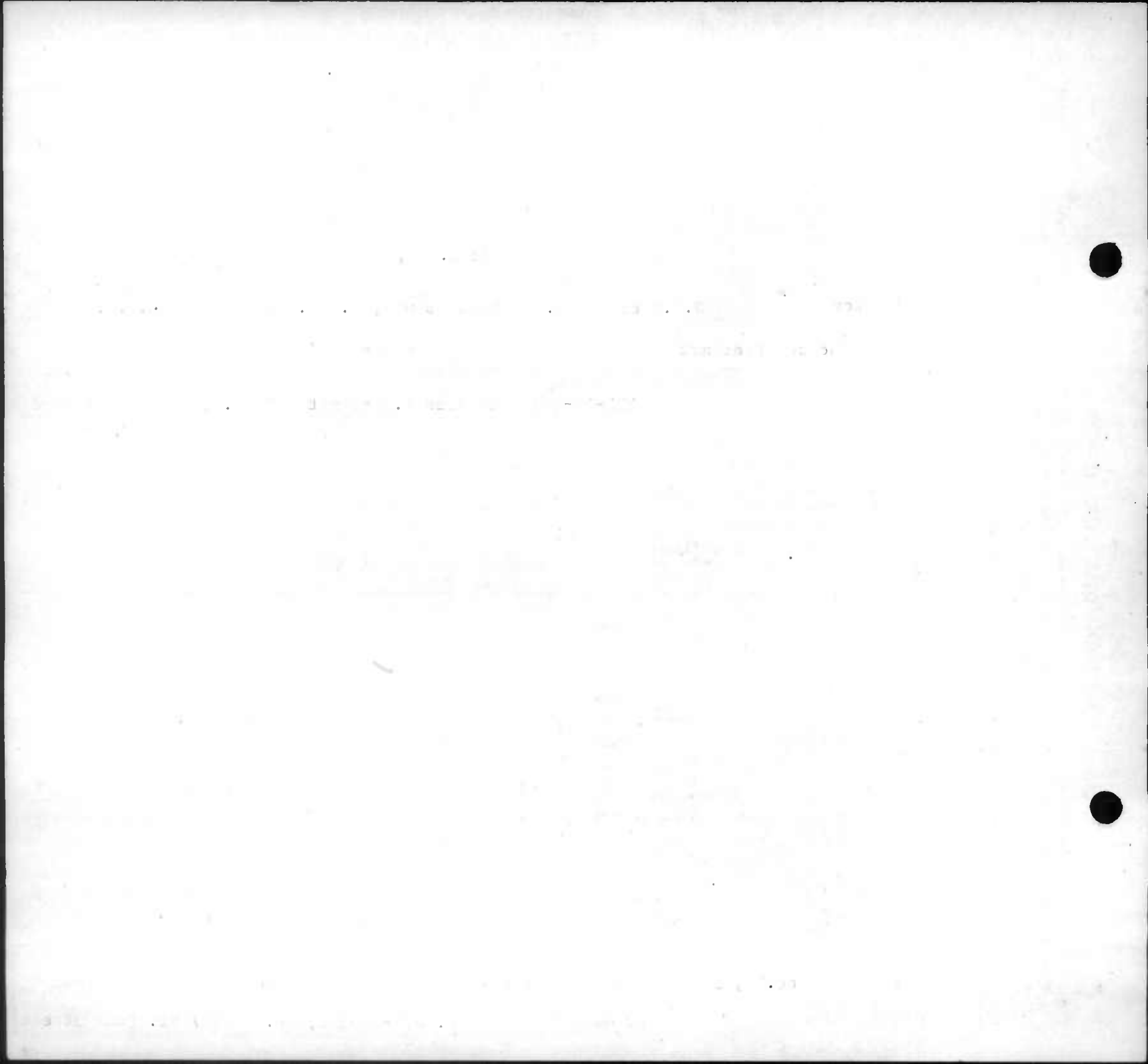
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|--|--|--|--|---|--|--|---------------------------------|--|
| BIRTH NO. 65 12857 | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | Registered No. 65 12857 | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| ANNIE MARY BROWN | | | | | Dec. 16, 1965 4 a. M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | A. STATE B. COUNTY | | | | |
| 3028 Clifton Park Terrace | | | | | Md. 21213 | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | |
| | | | | | Baltimore | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) | | | | |
| | | | | | 3028 Clifton Park Terrace | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | |
| female | | white | | widowed | | 8/11/1877 | | 88 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | |
| Housewife | | | | | at home | | | | |
| 11. BIRTHPLACE (State or foreign country) | | | | | 12. CITIZEN OF WHAT COUNTRY? | | | | |
| Baltimore, Md. | | | | | | | | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | |
| John Clopein | | | | | unknown | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | | | |
| | | | | | | | | | |
| 17. INFORMANT | | | | | ADDRESS | | | | |
| John A. Brown, son, above | | | | | | | | | |
| 18. CAUSE OF DEATH | | | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | |
| ANTECEDENT CAUSES | | | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| Sunday Aneurysm | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 21 1965 to Dec 16 1965, that (I) (we) last saw the deceased alive on Dec 16 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | | 23B. DATE SIGNED | | | | |
| Walter A. Anderson M.D. | | | | | Dec. 17-65 | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS | | | | |
| Dr. W. A. Anderson M.D. | | | | | 3001 Shannon Drive | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 12/18/65 | | Western Cemetery | | Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| DEC 20 1965 | | Robert E. Feltz, M.D. | | Schimmdig Funeral Home, Inc. | | 3331 Brehms Lane | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12858 | |
|--|-----------|--|---|--|---|
| BIRTH NO. 65 12858 | | CERTIFICATE OF DEATH | | Registered No. 65 12858 | |
| M.E. CASE NO. 1. NAME OF DECEASED LEE ELMER EVERHART (Type or Print) | | 2. DATE AND HOUR OF DEATH Dec. 15 1965 2:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 19-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1415 W. BALTIMORE ST. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M | 8. DATE OF BIRTH Sept. 29, 1911 | 9. AGE (In years last birthday) 54 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | 10B. KIND OF BUSINESS OR INDUSTRY J.R. Sherman Co. | | 11. BIRTHPLACE (State or foreign country) Martinsburg, W. Va. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Jackson Everhart | | | 14. MOTHER'S MAIDEN NAME Vallie (unknown) | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 232-26-4030 | | 17. INFORMANT ADDRESS (23) Mildred E. Everhart 222 S. Franklinton Road | |
| 18. 592X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) CHRONIC GLOMERULONEPHRITIS DUE TO WITH CHRONIC UREMIA (B) DUE TO (C) BRONCHOPNEUMONIA BILATERAL | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) ✓ | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from DEC. 12 1965 to DEC. 15 1965, that (I) (we) last saw the deceased alive on DEC. 15 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Wilfredo M. Mediano M.D. | | | | 23B. DATE SIGNED 12-15-65 | |
| 23C. PHYSICIAN'S NAME (Type) WILFREDO M. MEDIANO | | 23D. ADDRESS M.D. FRANKLIN SQUARE HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Dec. 18, 65 | | 24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | |
| 24D. LOCATION Baltimore County | | 24E. LOCATION (City, town, or county) (State) Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 20 1965 | | 25B. NAME OF REGISTRAR R. L. E. Fisher | | 25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks, Inc. 1217 St. Paul Street | |

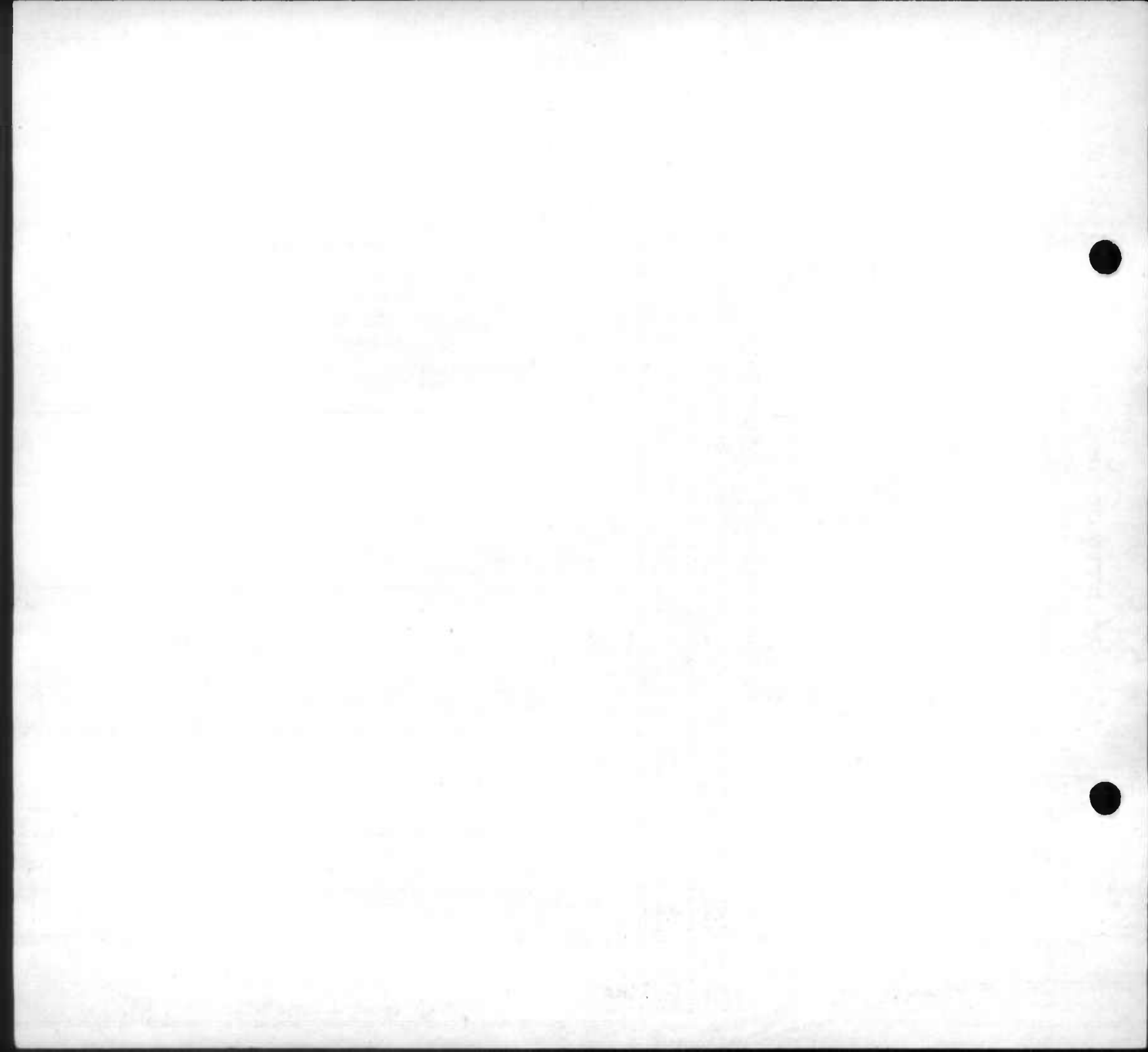


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|---|--|-------------------------|--|---|--|------------------------------------|--|---|--|--|--|------------------------------|--|--|
| BIRTH NO. 65 12859 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 12859 | | | | |
| 1. NAME OF DECEASED
(Type or Print) LEWIS LANG | | | | | 2. DATE AND HOUR OF DEATH
12-14-65 5:10 P. M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY 26-44 | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 3413 E. FAYETTE ST. | | | | | | | | | |
| 5. SEX
MALE | | 6. RACE
WHITE | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) WIDOWED | | 8. DATE OF BIRTH
3-21-86 | | 9. AGE (In years last birthday) 79 | | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) BALTIMORE | | | | |
| 13. FATHER'S NAME
JOHN LANG | | | | | 14. MOTHER'S MAIDEN NAME
SUSAN SNYDER | | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO.
214-01-9802 | | | | | 17. INFORMANT
EDNA LANG ADDRESS 3413 E. FAYETTE BALTO MD. | | | | |
| 18. 561.51 CAUSE OF DEATH | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ASPIRATION PNEUMONIA | | | | | | | | | | 5 DAYS | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
STRANGULATED INGUINAL HERNIA | | | | | | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
CHRONIC BRONCHITIS
CONGESTIVE HEART FAILURE, COMPENSATED | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION
12-9-65 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED STRANGULATED INGUINAL HERNIA | | | | | 20A. AUTOPSY? (Yes or No) NO | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (H) (this hospital) attended the deceased from DECEMBER 9 19 65 to DECEMBER 14 19 65 , that (H) (we) last saw the deceased alive on DECEMBER 14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE Rosario D. Bello M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | | | | | | 23B. DATE SIGNED 12-14-65 | | | | |
| 23C. PHYSICIAN'S NAME (Type) ROSARIO D. BELLO M.D. | | | | | | | | | | 23D. ADDRESS | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | | 24B. DATE 12-17-65 | | | | | 24C. NAME OF CEMETERY or CREMATORY Oak Lawn | | | | |
| | | | | | | | | | | 24D. LOCATION (City, town, or county) (State) Baltimore Co., Md., | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 20 1965 | | | | | | | | | | 25B. NAME OF REGISTRAR Ulrich Funeral Home Baltimore, Md. | | | | |
| | | | | | | | | | | 25C. FUNERAL DIRECTOR ADDRESS | | | | |



VALLEY FORGE

HAD CONTENT

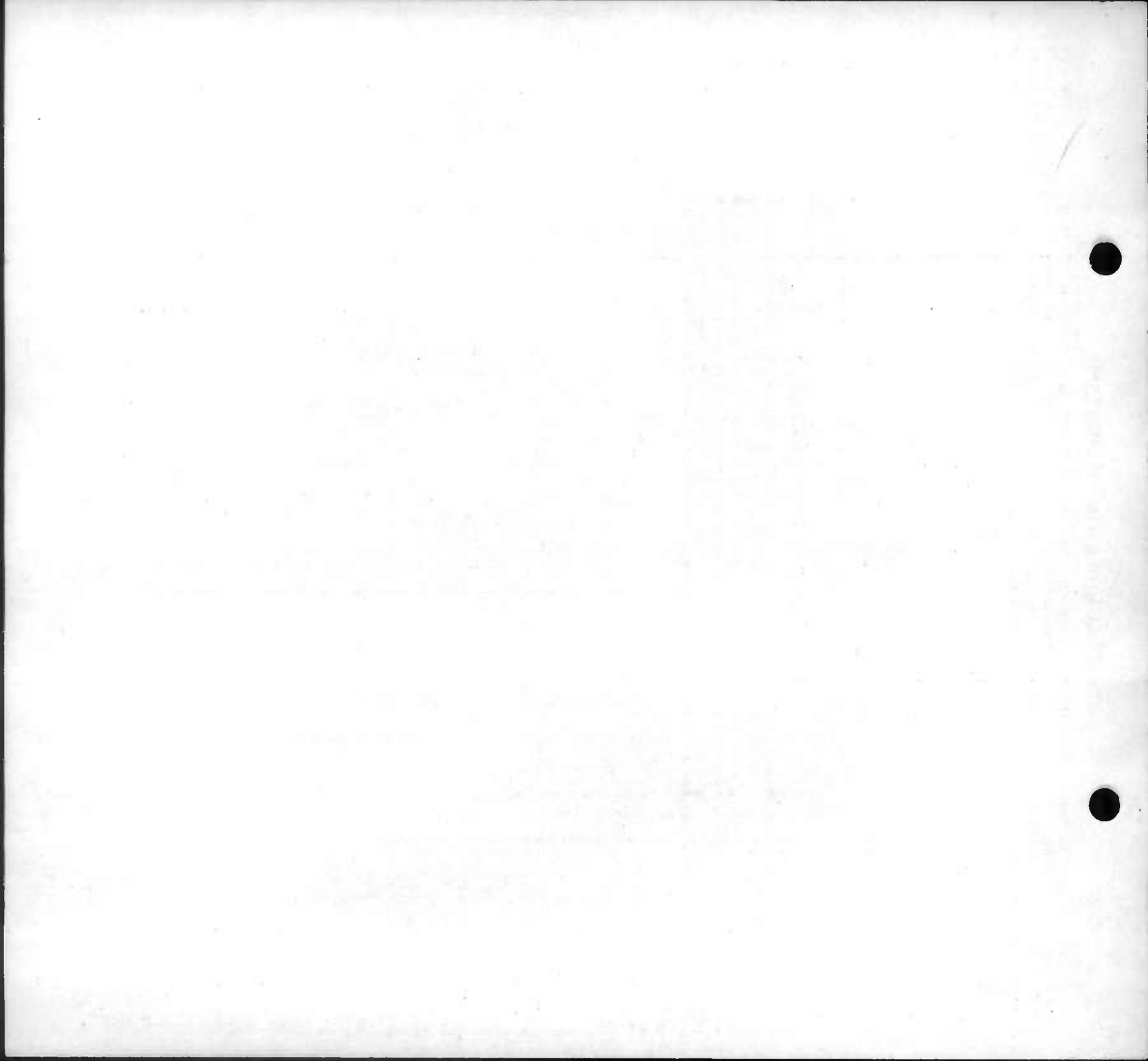
1776

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

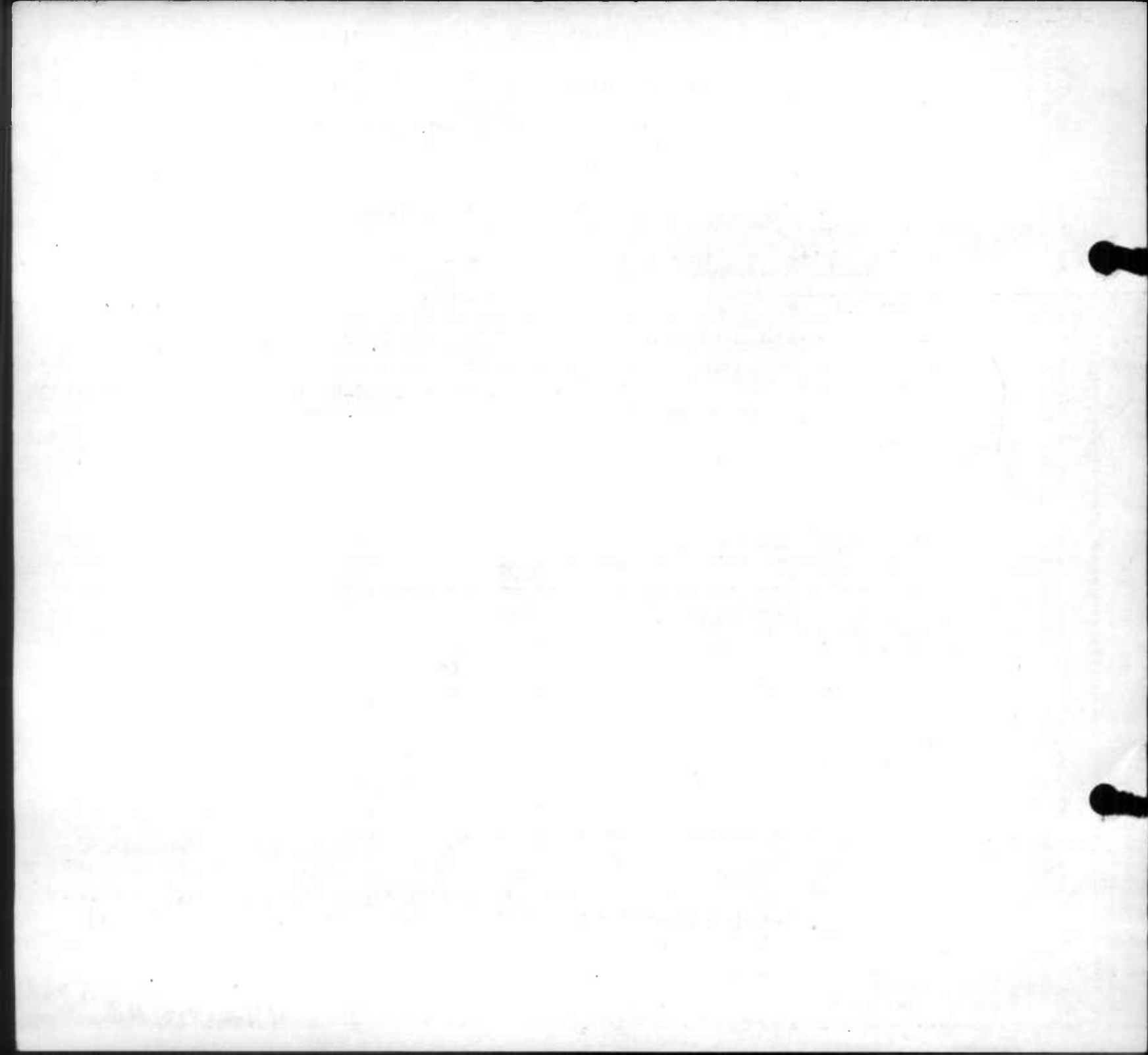
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | |
|--|--|------------------|--|---|--|------------------------------------|--|---|--|--|--|--|--|--|--|
| 65 12861 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 12861 | | | | | |
| BIRTH NO. | | | | | M.E. CASE NO. | | | | | 1. NAME OF DECEASED
(Type or Print) | | | | | |
| | | | | | Eleanor L. Cooksey | | | | | 2. DATE AND HOUR OF DEATH
December 17, 1965 | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY | | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | | | Maryland | | | | | 9-04 | | | | | |
| 600 E. 31st Street | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | | | | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
600 E. 31st Street | | | | | | | | | | |
| 5. SEX
Female | | 6. RACE
White | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | | 8. DATE OF BIRTH
April 12, 1885 | | 9. AGE (In years last birthday)
82 | | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Restaurateur-Ret. | | | | 10B. KIND OF BUSINESS OR INDUSTRY
Food | | | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
Charles M. Rahe | | | | | 14. MOTHER'S MAIDEN NAME
Mary E. Bach | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | | 16. SOCIAL SECURITY NO.
212-30-1894 | | | | | 17. INFORMANT
Edward P. Rahe 4115 Westview Road. | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH
(A) Pulmonary Edema
DUE TO
(B) Metastases to Pleura
DUE TO
(C) Carcinoma of the Breast | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 d.
3 months
3 years | | | | | |
| | | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
none | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No)
no | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 1963 to Dec 16 1965, that (I) (we) last saw the deceased alive on Dec 16 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 23A. SIGNATURE
George J. Richards, Jr. | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | 23B. DATE SIGNED
12/17/65 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS
Greater Baltimore Medical Center | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | | 24B. DATE
12.20/65 | | | | | 24C. NAME of CEMETERY or CREMATORY
St. John's Cemetery | | | | | |
| | | | | | | | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | | | | 25B. NAME OF REGISTRAR
John A. E. Jones | | | | | 25C. FUNERAL DIRECTOR
Ulrich Funeral Home 4210 Belair Road. | | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|---|---|
| E-540
65 12862 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 65 12862 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Violet May Enlow | | 12-15-65 1 8 ³⁰ PM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224 | | Maryland Baltimore | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | (Rural) 5380 | |
| | | D. STREET ADDRESS (If rural, give location) | | 43 Transverse Avenue 21220 | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | B. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| Female | White | Married | 5-2-1918 | 47 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | Home | | Canada | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Hjalmar Victor | | Clara M. Knutson | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | None | | Records: BCH-4940 Eastern Avenue 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 170X I | | METASTATIC Carcinoma of the Brain | | 2 years | |
| ANTECEDENT CAUSES | | (A) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 2 | | Yes | Yes | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-29-65 19 to 12-15-65 19, that (I) (we) last saw the deceased alive on 12-15-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| J. Patrick Caulfield | | | | 12-15-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| J. Patrick Caulfield | | 4940 Eastern Avenue, Baltimore BALT. CITY Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | 12-18-1965 | Oaklawn Cemetery | | Baltimore Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | | ADDRESS (36) | |
| DEC 20 1965 | Robert E. Fisher | Lashley Funeral Home 7401 Belair Road | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|---|-------------------------------------|---|--|
| BIRTH NO.
65 12863 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 65 12863 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) EDWARD J. GREEN | | 2. DATE AND HOUR OF DEATH
12-16-65 12 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 29 28-04 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
34 Bon Secours Hospital | | D. STREET ADDRESS (If rural, give location)
4911 Briarcliff Road | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
12/26/91 | 9. AGE (In years last birthday)
73 | 10. Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY
F. A. DAVIS CO. | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
John D. Green | | 14. MOTHER'S MAIDEN NAME
SARANDA HARRIS | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213-034399 | | 17. INFORMANT
4911 BRIARCLIFF RD. ADDRESS BALTO. MD. (29)
Mrs. KATHERINE E. GREEN | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
420.1 I | | CAUSE OF DEATH
(A) Cardiac arrest
DUE TO
(B) Myocardial infarction poss.
DUE TO
(C) Arterio sclerotic heart disease | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from December 7, 1965 to December 15, 1965 , that (I) (we) last saw the deceased alive on 15 December 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Octavio A. Ruiz | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
12/16/65 | |
| 23C. PHYSICIAN'S NAME (Type)
Octavio A. Ruiz | | 23D. ADDRESS
M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12/18/65 | | 24C. NAME OF CEMETERY OR CREMATORY
LORRAINE PARK CEM. | |
| 24D. LOCATION
BALTO. MD. | | 24E. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 24F. NAME OF REGISTRAR
DEC 20 1965 | |
| 24G. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 24H. NAME OF REGISTRAR
DEC 20 1965 | | 24I. FUNERAL DIRECTOR
G. PRUMAN | |
| 24J. ADDRESS
3512 Fred Ave. BALTO. 29. Md. | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|---------|--|-----------------------------------|---|---|--|------------------------------|
| 45-12-49
NIW
A431 | | 65 12864 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 12864 | |
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) ALTVATER Catherine | | | | 12-12-65 12:50 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| Baltimore City Hospitals | | Baltimore City Hospitals | | 812 S. Highland Ave. | | D.C. 26-11 | |
| 4940 Eastern Avenue | | 4940 Eastern Avenue | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Balto, Md 21224 | |
| Baltimore, Maryland 21224 | | Baltimore, Maryland 21224 | | D. STREET ADDRESS (If rural, give location) | | 812 S. Highland Ave | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months: Days | 11. Under 24 Hrs. Hours: Min. | 12. CITIZEN OF WHAT COUNTRY? |
| F | Wh | Widowed | 12-26-79 | 85 | | | U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Retired | | | Balto. City Worker | | MARYLAND | | U.S.A. |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| John W Waxmuth | | | | Catherine Theresea? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| NO | | None | | RECORDS: BCH 4940 Eastern Ave., Balto. Md. 21224 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | Ser. yrs. | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 11-11-65 | | Gangrene of foot | | Yes | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nailly medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-11-65 to 12-12-65, that (I) (we) lost saw the deceased alive on Dec 12 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Eusebio C. Kho, M.D. | | | | 12-12-65 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| EUSEBIO C. KHO M.D. | | | | 4940 Eastern Ave., Balto. Md. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | | | 12-15-65 | | Mount Carmel Cemetery | |
| 24D. LOCATION (City, town, or county) (State) | | | | 24E. DATE RECEIVED BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR | |
| 5712 O'Donnell St. Balto. Md. | | | | DEC 20 1965 | | Charles S. Zeiler 901 S. Conkling St. #24 | |

10-10-1917
10-10-1917

10-10-1917

10-10-1917

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>5 12865</u> | |
|--|-------------------------|--|--|--|---|
| BIRTH NO. <u>65 12865</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Mary G. Kernan.</u> | | 2. DATE AND HOUR OF DEATH
<u>Dec 16, 1965</u> <u>9:30 P.</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Maryland</u>
B. COUNTY <u>9-06</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>1707 E. 28th St.</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<u>1707 E. 28th St</u> | | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>July 23, 1895</u> | 9. AGE (In years last birthday)
<u>70</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 13. FATHER'S NAME
<u>John E. Melvin.</u> | | 14. MOTHER'S MAIDEN NAME
<u>Catherine Beuley.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>—</u> | | 16. SOCIAL SECURITY NO.
<u>?</u> | | 17. INFORMANT
<u>Bernard P. Kernan.</u> | |
| | | | | ADDRESS
<u>1707 E. 28th St</u> | |
| 18. <u>420.114-2601</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
<u>Coronary Occlusion</u> | | CAUSE OF DEATH
(A) DUE TO
<u>Coronary Occlusion</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>30 minutes</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO
<u>Coronary Artery Disease</u> | | <u>2 years</u> | |
| | | (C) | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <u>Diabetes Mellitus</u> | | <u>12 years</u> | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1956</u> 19 <u>to</u> <u>December</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Dec 16</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Loy M. Zimmerman</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>Dec 17, 65</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Loy M. Zimmerman</u> | | M.D. 23D. ADDRESS
<u>3202 Hartford Rd Baltimore Md</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>12/18/65</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>St. Mary's, Hampden</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State)
<u>3900 Roland Ave, Balto, Md</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>DEC 20 1965</u> | | 25B. NAME OF REGISTRAR
<u>Paul E. Fisher</u> | | 25C. FUNERAL DIRECTOR
<u>Austin E. Donovan</u> | |
| | | | | ADDRESS
<u>3818 Roland Ave</u> | |

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN F. RICHARDS

2. DATE AND HOUR PRONOUNCED DEAD

December 16, 1965 7:15 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4313 Brehms Lane

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

June 4, 1913

9. AGE (In years
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Lab Technician

10B. KIND OF BUSINESS OR INDUSTRY

Veterans Hosp
Loch Raven

11. BIRTHPLACE (State or foreign country)

Phila. Pa

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Benjamin F. Richards

14. MOTHER'S MAIDEN NAME

Bertha Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

Yes

2n W.W.

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Florence S. Richards. 4313 Brehms Lane

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Hypertensive and Arteriosclerotic
Cardiovascular Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/17/65

23A. BURIAL CREMATION,
REMOVAL

Removal

23B. DATE

12/19/65

23C. NAME of CEMETERY or CREMATORY

Mazepa

23D. LOCATION

(City, town, or county)

(State)

Minnesota.

24A. DATE REC'D BY HEALTH DEPT.

DEC 20 1965

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

VALLEY

June 1, 1913

Received

from

John Davidson

for

John Davidson

for

John Davidson

Received

from

John Davidson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|---|---------------------|--|---|--|---|---|--|---|--|---|--|--|--|--|
| 65 12867 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 12867 | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>WOJITAS, Frances Cecilia (ma)</i> | | | | | | | | | | 2. DATE AND HOUR OF DEATH
<i>Dec. 16, 1965</i> 29. M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>Montebello State Hospital</i> | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>HOL</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i>
D. STREET ADDRESS (If rural, give location)
<i>3103 ZILBERT ST.</i> | | | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>W</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>widowed</i> | | | 8. DATE OF BIRTH
<i>3-31-10</i> | 9. AGE (In years last birthday)
<i>55</i> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Saleswoman</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Bakery</i> | | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | | | |
| 13. FATHER'S NAME
<i>Anthony WOJITAS</i> | | | | | 14. MOTHER'S MAIDEN NAME
XXXXXXXXXX <i>CECILIA BIALECKA</i> | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | | 16. SOCIAL SECURITY NO.
<i>216-18-6534</i> | | 17. INFORMANT
<i>Hospital Chaplain - THEODORE WOJITAS</i>
<i>357 GUSRYAN ST. 21224</i> | | | | | | | | | |
| 18. <i>154X I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>Carcinoma of rectum with metastasis</i>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<i>Cause unknown</i> | | | | | | | | | | CAUSE OF DEATH
(A) <i>Carcinoma of rectum with metastasis</i>
(B) <i>Cause unknown</i>
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<i>3-4 years</i> | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
_____ | | | 20A. AUTOPSY? (Yes or No)
<i>NO</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
_____ | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
_____ | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
_____ | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
_____ | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
_____ | | | 21E. INJURY OCCURRED While At _____ Not While _____ Work _____ AT Work _____ | | | 21F. HOW DID INJURY OCCUR?
_____ | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Oct. 1, 1965</i> to <i>December 16, 1965</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>December 16, 1965</i> and that (in my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We)</i> <i>(did)</i> <i>(did not)</i> view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE
<i>Cesar J. Polkano</i> M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
<i>Dec. 16, 1965</i> | | | | | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Cesar J. Polkano</i> M.D. | | | | | 23D. ADDRESS
<i>Montebello Hospital</i> | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 24B. DATE
<i>12-20-65</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>ST. STANISLAUS CEM.</i> | | | 24D. LOCATION (City, town, or county) (State)
<i>BALTIMORE, MD.</i> | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>DEC 20 1965</i> | | | 25B. NAME OF REGISTRAR
<i>Robert E. J...</i> | | | 25C. FUNERAL DIRECTOR
<i>Wm. J. Fialkowski</i> | | | ADDRESS
<i>2007 Eastern Ave. Balto. Md. 21231</i> | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|--|--|---------------------------|--|---|--|--|--|--|-------------------------------------|--|--|
| BIRTH NO. <i>R. Geo. 6, 12868</i> | | | | | CERTIFICATE OF DEATH | | | | | Registered No. <i>65 12868</i> | |
| 1. NAME OF DECEASED
(Type or Print) VALERIE C. THOMPSON | | | | | 2. DATE AND HOUR OF DEATH
<i>12-11-65 13:15 A. M.</i> | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MARYLAND B. COUNTY CHARLES | | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BEL ALTON | | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <i>5800</i> | | | | | | |
| 5. SEX
FEMALE | | 6. RACE
NEGRO | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED, (specify) NEVER MARRIED | | 8. DATE OF BIRTH
1-1-64 | | 9. AGE (In years last birthday) 1 | | If Under 1 Yr. Monthly Days XXXXXX | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>none</i> | | 11. BIRTHPLACE (State or foreign country) <i>Prince George Co Md</i> | | | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME
JOHN MARYLAND THOMPSON | | | | | | 14. MOTHER'S MAIDEN NAME
MARY E. BUTLER | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | | | 16. SOCIAL SECURITY NO. <i>no</i> | | 17. INFORMANT ADDRESS
<i>John M Thompson Bel Alton Md</i> | | | | | |
| 18. <i>289.31</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | CAUSE OF DEATH
(A) <i>Cryptic fibrosis</i>
DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| | | | | | | (B) DUE TO | | | | | |
| | | | | | | (C) DUE TO | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10-25-65</i> to <i>12-11-65</i> 19 <i>65</i> , that (I) <u>we</u> last saw the deceased alive on <i>12-11</i> 19 <i>65</i> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> <u>did</u> (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
<i>Christine Simmons</i> | | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED
<i>12-11-65</i> | | |
| 23C. PHYSICIAN'S NAME (Type) <i>Christine Simmons</i> | | | | | | 23D. ADDRESS
M.D. JOHNS HOPKINS HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12/13/65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>St Thomas Cemetery</i> | | | | 24D. LOCATION (City, town, or county) (State) <i>Bel Alton Md</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 20 1965 | | | | 25B. NAME OF REGISTRAR <i>R. Geo. 6, 12868</i> | | | | 25C. FUNERAL DIRECTOR <i>Richard J. Koplata</i> ADDRESS <i>Md</i> | | | |



| 65 12869 | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 12869 | |
|--|---------|---|------------------|--|--|
| BIRTH NO. | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| | | CRANSTON HURT | | December 17, 1965 10:00 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE Maryland | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | B. COUNTY | | | |
| 920 W. North Avenue | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | | |
| | | Baltimore 13-02 | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 920 W. North Avenue | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years
last birthday) | 10. Under 1 Yr. 11 Under 24 Hrs.
Months Days Hours Min. |
| Male | White | MARRIED | June 27, 1926 | 39 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| UNEMP. | | | | KENTUCKY | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| UNK | | UNK | | USA | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| Yes WW II | | | | FAMILY 417 Patapsco Ave. | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | Acute Ethylism. | | | |
| (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (C) | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 22. | | I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER | | DATE SIGNED | |
| EXAMINER'S NAME (Type) | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 12/17/65 | |
| Charles S. Petty, M.D. | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 12-21-65 | | Bulto Nat. Cem. | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR | |
| DEC 20 1965 | | Robert E. Petty | | McGilly Funeral Home | |
| | | 965001 | | 237 Patapsco Ave. Bulto 25 Jan | |

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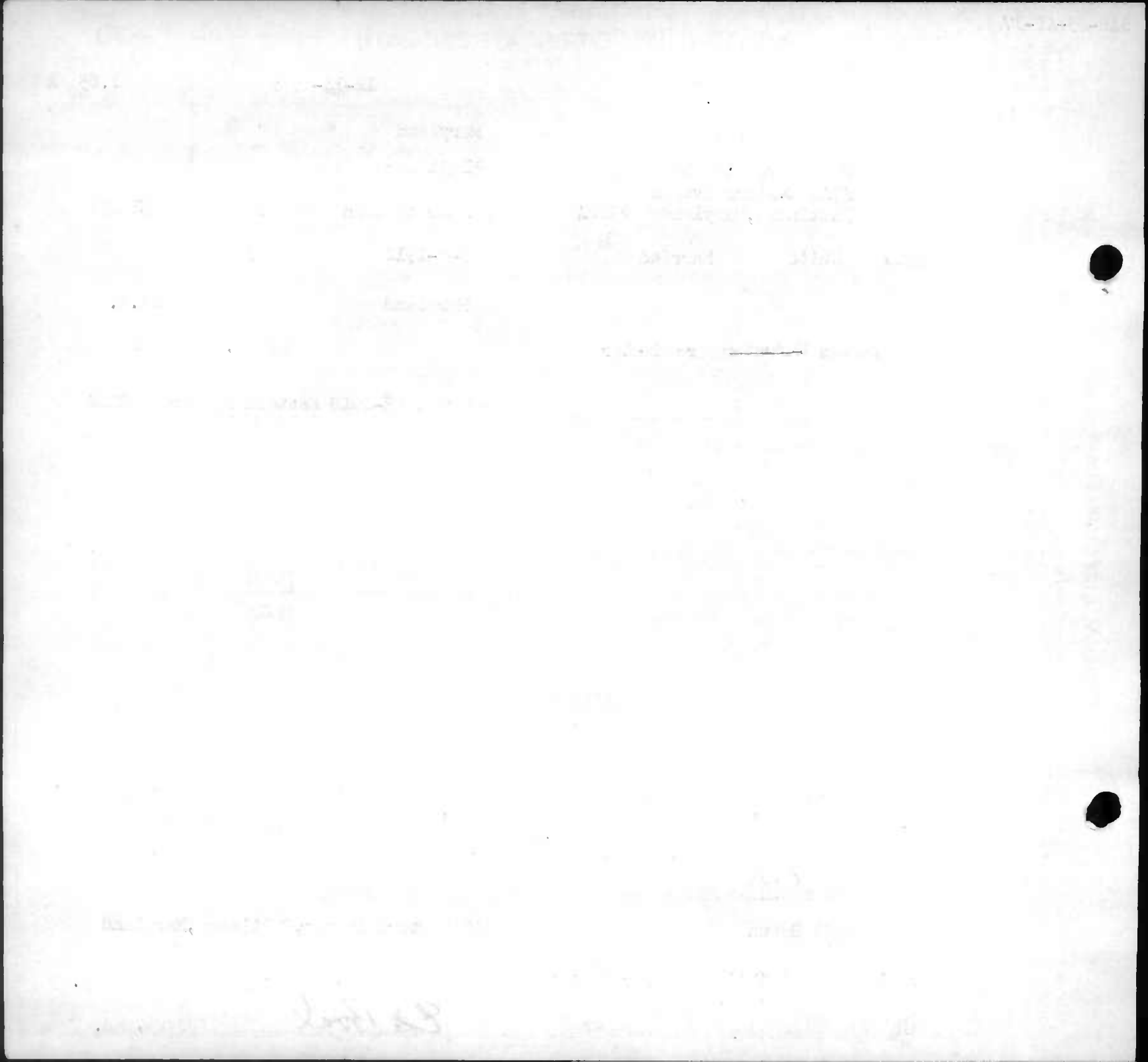
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|-------------------------------------|---|---|
| BIRTH NO. 65 12870 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 12870 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Nancy Spiker | | 2. DATE AND HOUR OF DEATH
12-14-1965 1.05 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland
B. COUNTY 302 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224 | | D. STREET ADDRESS (If rural, give location)
404 South Eden Street | | 21231 | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
5-8-1912 | 9. AGE (In years last birthday)
53 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Thomas Budwater Broadwater | | 14. MOTHER'S MAIDEN NAME
Mary E. Binneger | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Records: BCH-4940 Eastern Avenue 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Adeno carcinoma of Lung | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
10 mo. | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from 12/9 19 65 to 12/14 19 65 , that (X) (we) last saw the deceased alive on 12/13 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Virgil Brown | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
12/14/65 | |
| 23C. PHYSICIAN'S NAME (Type)
Virgil Brown | | 23D. ADDRESS
M.D. 4940 Eastern Avenue, Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12/17/65 | | 24C. NAME OF CEMETERY or CREMATORY
Laurel Hill | |
| 24D. LOCATION (City, town, or county) (State)
Moscow Mills Md. | | 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS
Westernport, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

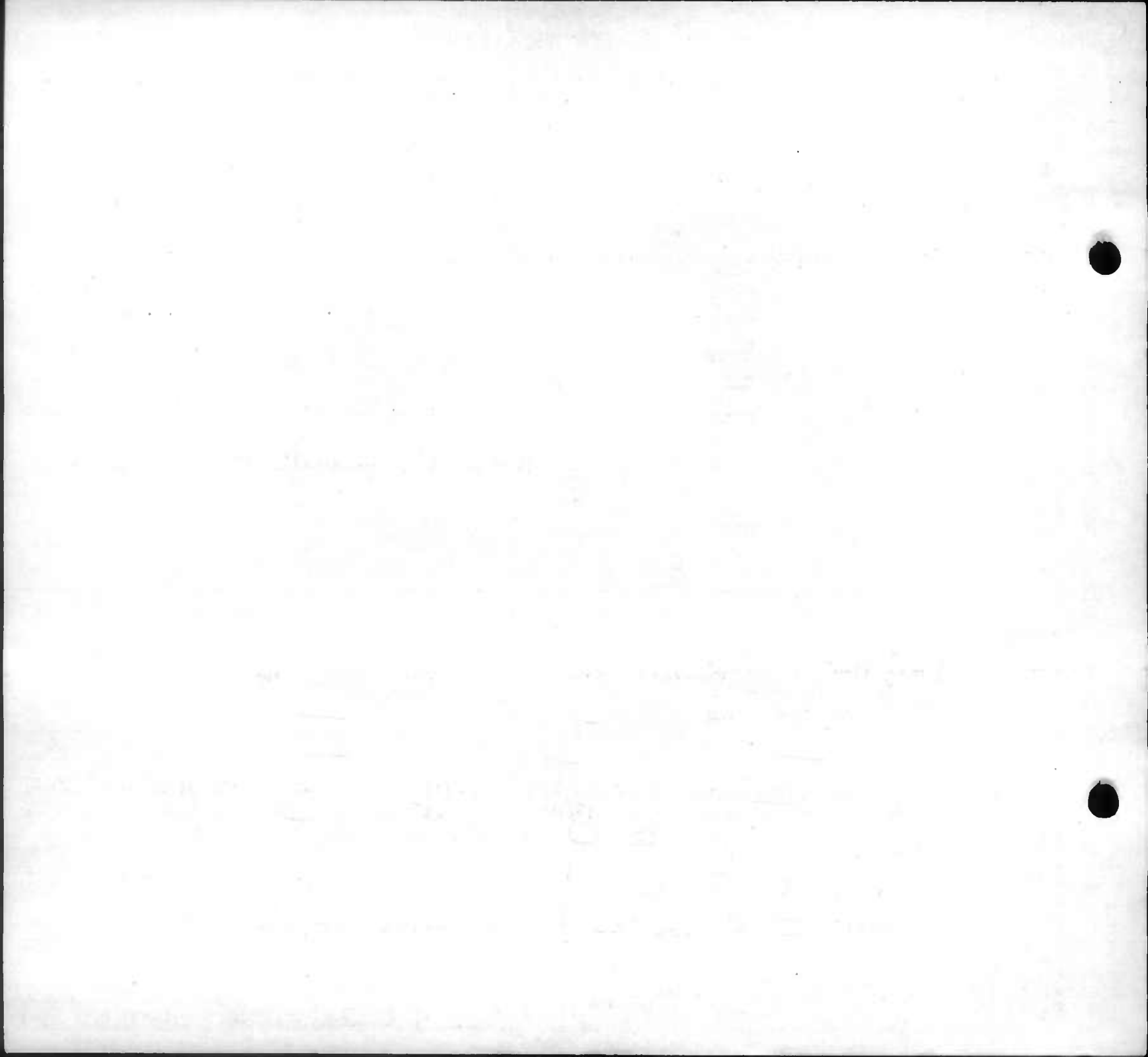
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 65 12871 | |
|--|--|--|--|---|--|
| <div>65 12871 65 31187</div> <div>CERTIFICATE OF DEATH</div> | | | | | |
| <div>M.E. CASE NO. <u>STULCH CATHERINE</u></div> | | | | | |
| <div>1. NAME OF DECEASED</div> <div>(Type or Print) <u>STULCH (Donna) BABY GIRL</u></div> | | | <div>2. DATE AND HOUR OF DEATH</div> <div><u>DEC 16, 1965 3:5 A</u> M.</div> | | |
| <div>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</div> <div><u>UNIVERSITY HOSPITAL</u></div> <div>FULL NAME OF HOSPITAL OR INSTITUTION <u>LOMBARD & GREEN STS. BALTO., MD. 21201</u></div> | | | <div>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</div> <div>A. STATE <u>MD.</u> B. COUNTY <u>19-03</u></div> | | |
| <div>5. SEX <u>F</u></div> | | | <div>6. RACE <u>W</u></div> | | |
| <div>7. MARRIED, NEVER MARRIED</div> <div><u>SINGLE</u></div> | | | <div>8. DATE OF BIRTH <u>12/15/65</u></div> | | |
| <div>9. AGE (In years last birthday)</div> <div><u>5</u></div> | | | <div>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div><u>—</u></div> | | |
| <div>11. BIRTHPLACE (State or foreign country)</div> <div><u>BALTO., MD</u></div> | | | <div>12. CITIZEN OF WHAT COUNTRY?</div> <div><u>USA</u></div> | | |
| <div>13. FATHER'S NAME</div> <div><u>CHARLES T. STULCH</u></div> | | | <div>14. MOTHER'S MAIDEN NAME</div> <div><u>DONNA D. DOMANSKI</u></div> | | |
| <div>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</div> <div><u>NO</u></div> | | | <div>16. SOCIAL SECURITY NO.</div> <div><u>—</u></div> | | |
| <div>17. INFORMANT</div> <div><u>LOUIS O. OLSEN, MD.</u></div> | | | <div>ADDRESS <u>UH</u></div> | | |
| <div>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</div> <div><u>761.0 I</u></div> | | | <div>CAUSE OF DEATH</div> <div>(A) <u>INTRA-ABDOMINAL HEMORRHAGE - 5 hrs</u></div> | | |
| <div>19. ANTECEDENT CAUSES</div> <div>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</div> <div><u>BIRTH TRAUMA</u></div> | | | <div>INTERVAL BETWEEN ONSET AND DEATH</div> <div><u>2° to UNUSUAL PRESENTATION</u></div> | | |
| <div>II</div> <div>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</div> | | | | | |
| <div>19A. DATE OF OPERATION</div> <div><u>2</u></div> | | <div>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</div> <div><u>—</u></div> | | <div>20A. AUTOPSY? (Yes or No)</div> <div><u>Yes</u></div> | |
| <div>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)</div> <div><u>No</u></div> | | <div>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</div> <div><u>—</u></div> | | <div>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</div> <div><u>—</u></div> | |
| <div>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</div> <div><u>—</u></div> | | <div>21E. INJURY OCCURRED</div> <div>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></div> | | <div>21F. HOW DID INJURY OCCUR?</div> <div><u>—</u></div> | |
| <div>22. I certify that (this hospital) attended the deceased from <u>12/16 1965</u> to <u>12/16 1965</u>, that (we) last saw the deceased alive on <u>12/16 1965</u> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</div> | | | | | |
| <div>23A. SIGNATURE</div> <div><u>LOUIS O. OLSEN</u></div> | | | | <div>23B. DATE SIGNED</div> <div><u>12/16/65</u></div> | |
| <div>23C. PHYSICIAN'S NAME (Type)</div> <div><u>LOUIS O. OLSEN</u></div> | | | | <div>23D. ADDRESS</div> <div><u>UNIV. HOSP. - BALTO., MD.</u></div> | |
| <div>24A. BURIAL CREMATION, REMOVAL (Specify)</div> <div><u>Burial</u></div> | | <div>24B. DATE</div> <div><u>12-17-65</u></div> | | <div>24C. NAME OF CEMETERY OR CREMATORY</div> <div><u>Bedar Hill Cemetery</u></div> | |
| <div>24D. LOCATION (City, town, or county) (State)</div> <div><u>Anne Arundel Co.</u></div> | | <div>25A. DATE REC'D BY HEALTH DEPT.</div> <div><u>DEC 20 1965</u></div> | | | |
| <div>25B. NAME OF REGISTRAR</div> <div><u>—</u></div> | | <div>25C. FUNERAL DIRECTOR</div> <div><u>Walter's Funeral Home</u></div> | | | |
| <div>25D. ADDRESS</div> <div><u>23 S. Stricker St.</u></div> | | <div>25E. ADDRESS</div> <div><u>—</u></div> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12872 | |
|--|-------------------------|---|---|---|---|
| BIRTH NO. 65 12872 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) CHARLES HILDEBRANDT | | 2. DATE AND HOUR OF DEATH
12-12-65 8:45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
THE JOHNS HOPKINS HOSPITAL | | A. STATE MARYLAND
B. COUNTY BALTIMORE | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location)
1738 MONTEPELIER STREET | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
9-1-99 | 9. AGE (In years last birthday)
66 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Bricklayer |
| | | 10B. KIND OF BUSINESS OR INDUSTRY
Meyerhoff | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
GEORGE Hildebrandt | | | 14. MOTHER'S MAIDEN NAME
MAIRE MARIE SCROGGS | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
<input checked="" type="checkbox"/> | 17. INFORMANT ADDRESS
Charles T. Hildebrandt 7203 Belair Rd | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
157X I
Metastatic pancreatic Ca | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
7 months | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | (B) DUE TO | |
| | | (C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
May 1965 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Pancreatic Ca | | 20A. AUTOPSY? (Yes or No)
yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
no | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/11 19 65 to 12/12 19 65 , that (I) (we) lost saw the deceased alive on 12/11 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Robert I. Keimowitz | | | | 23B. DATE SIGNED
12/12/65 | |
| 23C. PHYSICIAN'S NAME (Type)
Robert I. Keimowitz | | 23D. ADDRESS
Johns Hopkins Hosp | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12-16-1965 | | 24C. NAME of CEMETERY or CREMATORY
Baltimore Cemetery | |
| | | 24D. LOCATION
Baltimore City Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 25B. NAME OF REGISTRAR
Robert I. Keimowitz | | 25C. FUNERAL DIRECTOR
Johns Hopkins Funeral Home 7401 Belair Rd | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12873 | |
|--|--------------|--|-----------------------------|--|--|
| 65 12873 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) | | Michael Anthony Gilbode | | 2. DATE AND HOUR OF DEATH
Dec. 15, 1965 9: 20 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Conn.
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Waterbury
D. STREET ADDRESS (If rural, give location) 153 Grandview Rd. | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
6/21/46 | 9. AGE (In years last birthday)
19 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Airman 2/c | | 10B. KIND OF BUSINESS OR INDUSTRY
USAF | | 11. BIRTHPLACE (State or foreign country)
Conn.
12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Joseph Gilbode | | 14. MOTHER'S MAIDEN NAME
Mary Lakevitch | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes Active USAF | | 16. SOCIAL SECURITY NO.
045-36-2349 | | 17. INFORMANT ADDRESS
Records- US PHS Hospital, Balto, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
Pulmonary edema
CAUSE OF DEATH
(A) DUE TO
Cardiac dilatation
(B) DUE TO
Acute lymphatic leukemia (clinical)
Subdural hemorrhage
Intramyocardial hemorrhage
INTERVAL BETWEEN ONSET AND DEATH
Hours
Hours
Months
Hours
Days | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 8 19 65 to Dec. 15 19 65, that (I) (we) last saw the deceased alive on Dec. 15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Thomas J. Lau, Surgeon (R) | | | | 23B. DATE SIGNED
12/16/65 | |
| 23C. PHYSICIAN'S NAME (Type)
Thomas J. Lau, Surgeon (R) | | | | 23D. ADDRESS
US PHS Hospital, Balto, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Removal | | 24B. DATE
12-16-65 | | 24C. NAME OF CEMETERY or CREMATORY
Mount Olivet | |
| 24D. LOCATION
Waterbury, Conn. | | 24E. NAME OF REGISTRAR
Wm. Cook | | 24F. FUNERAL DIRECTOR ADDRESS
Brooks Inc. 1217 St. Paul St. | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 25B. NAME OF REGISTRAR
Wm. Cook | | 25C. FUNERAL DIRECTOR ADDRESS
Brooks Inc. 1217 St. Paul St. | |

THE UNIVERSITY OF CHICAGO
LIBRARY
CHICAGO, ILL.

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| BIRTH NO. 65 12874 | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 12874 | |
|---|---------|--|---|--|---|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | 2. DATE AND HOUR PRONOUNCED DEAD | | |
| ROBERT ATHEY | | | 12/15/65 8:05 a. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Sinai Hospital | | | A. STATE
Maryland | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | |
| | | | Baltimore 27-17 | | |
| | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | 5032 Palmer Ave. | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years
last birthday) | 10. If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. |
| male | white | Divorced | (Unknown) 1913 | 52 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Labourer | | Unknown | | Kannapolis, N.C. | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| (Unknown) Athey | | | Unknown | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| (Unknown) ----- | | Unknown | | Lady's Funeral Home Kannapolis, N.C. | |
| 18. CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | (A) Craniocerebral injury and subdural hematoma | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | (B) DUE TO | | |
| | | | (C) DUE TO | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | home | | 5032 Palmer Ave. 27-17 | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | fell down steps | |
| 12 15 65 ? | | | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type) | | | | DATE SIGNED | |
| Werner U. Spitz, M.D. | | | | 12/15/65 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME OF CEMETERY or CREMATORY | |
| Removal | | 12/16/65 | | Kannapolis, N.C. | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR ADDRESS | |
| DEC 20 1965 | | Robert E. Williams | | Wm. Cook-Brooks Inc 1217 St. Paul St.
Baltimore, Md. 21202 | |

WALTER HOPKINS

WALTER HOPKINS

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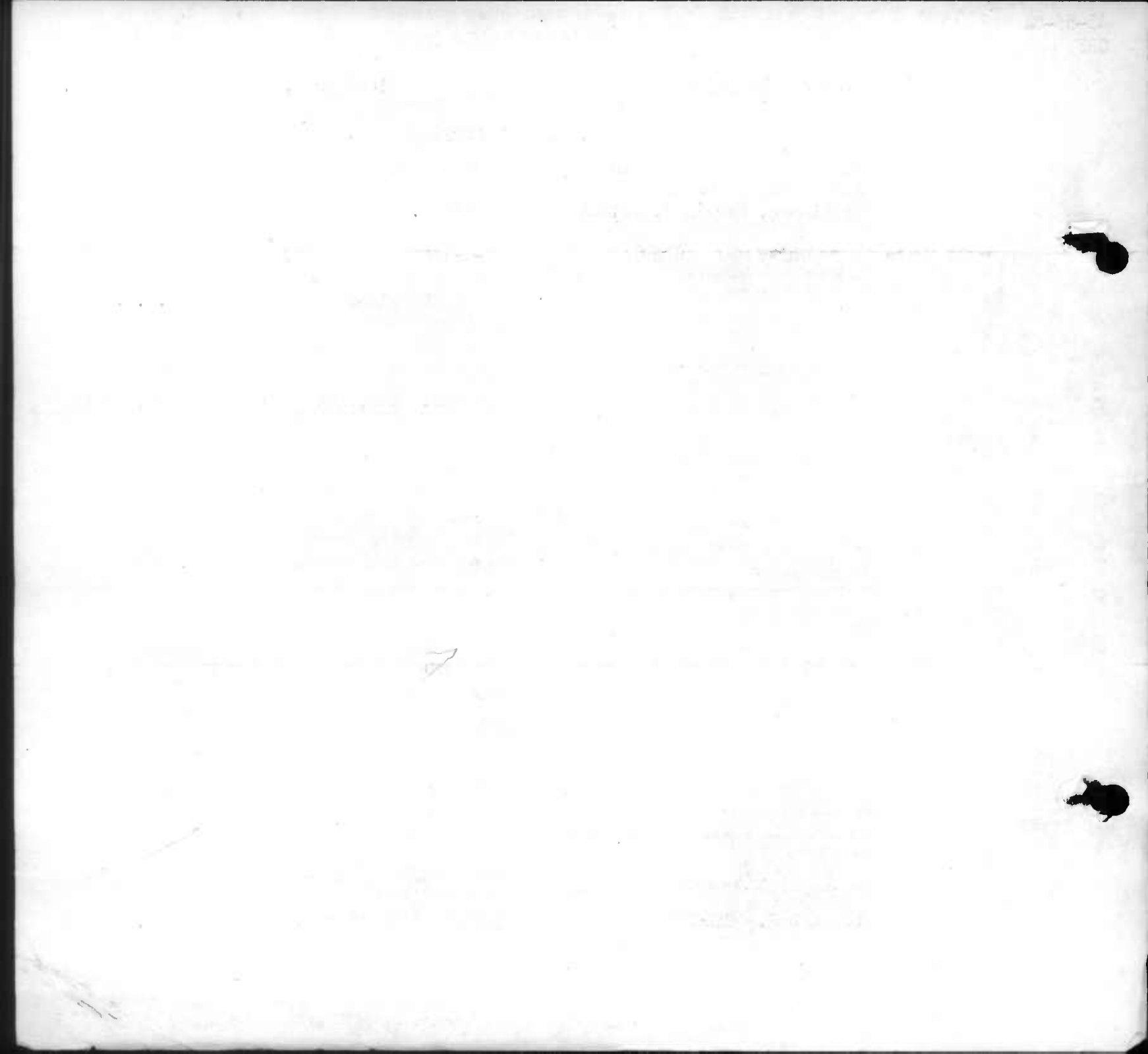
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12875 | |
|---|------------------|---|------------------------------|--|---|
| BIRTH NO. 1-213 65 12875 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Joseph McFadden | | 2. DATE AND HOUR OF DEATH
December 3, 1965 2:20 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Maryland
B. COUNTY 4-01 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland, #21224 | | O. STREET ADDRESS (If rural, give location)
613 E. Baltimore Street | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
1-9-1888 | 9. AGE (In years last birthday)
77 | If Under 1 Yr. Months: Ooys: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS
RECORDS: BCH, 4940 Eastern Avenue, #21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
420.0
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) DUE TO CARDIAC ARRHYTHMIA
ARTERIOSCLEROTIC HEART DISEASE
(B) DUE TO POST-ICHTAL STATE
STATUS EPILEPTICUS
(C) ASPIRATION PNEUMONIA | | INTERVAL BETWEEN ONSET AND DEATH
MOMENT OF DEATH
3 days
3 days | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/10/1965 to 12/3/1965, that (I) (we) last saw the deceased alive on 12/3/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Leonard J. Quadracci | | | | 23B. DATE SIGNED
12/3/65 | |
| 23C. PHYSICIAN'S NAME (Type)
LEONARD J. QUADRACCI | | | | 23D. ADDRESS
M.O. 4940 Eastern Avenue, Baltimore, Md., #21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12-17-65 | | 24C. NAME OF CEMETERY OR CREMATORY
Sacred Heart Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore Md. | | 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 25B. NAME OF REGISTRAR
Robert E. [unclear] | |
| 25C. FUNERAL DIRECTOR
Walter [unclear] | | 25D. ADDRESS
1005 [unclear] Ave. | | | |



65 12876

BALTIMORE CITY HEALTH DEPARTMENT

65 12876

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JEAN P. AUSTIN

2. DATE AND HOUR PRONOUNCED DEAD

12-13-65

7:52 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1306 E. Mounment Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

1-10-28

9. AGE (in years
last birthday)

37

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

WAITRESS

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

SAMUEL AUSTIN

14. MOTHER'S MAIDEN NAME

Theresa SAVAGE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Ruth Thaxton 1913 E. Federal St.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Massive subarachnoid hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Rupture of congenital aneurysm
of circle of Willis

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Hypertensive heart disease

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

RUSSELL S. FISHER, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

12-13-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

12/18/65

23C. NAME of CEMETERY or CREMATORY

MT. CALVARY

23D. LOCATION

(City, town, or county)

A.A. COUNTY, MD

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 20 1965

24B. NAME OF REGISTRAR

R. S. Fisher

24C. FUNERAL DIRECTOR

Joseph B. Lock 1304 N. Central Ave

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>65 12877</u> | |
|--|-------------------------|---|-----------------------------------|---|---|--|--|
| BIRTH NO. <u>65 12877</u> | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>MARGARET C. O'BRIEN</u> | | 2. DATE AND HOUR OF DEATH
<u>12/16/65</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>House in the Pines N.H.
Belvedere Avenue</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Maryland</u>
B. COUNTY <u>12-02</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u>
D. STREET ADDRESS (If rural, give location)
<u>Hopkins Apts.</u> | | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Single</u> | 8. DATE OF BIRTH
<u>1882</u> | | 9. AGE (In years last birthday)
<u>83</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>housewife</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 13. FATHER'S NAME
<u>Ja.es 08Brien</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Margaret McShane</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Mrs. Kathleen Mooney-504 Windwood Rd.</u> | | |
| 18. <u>332X1</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)

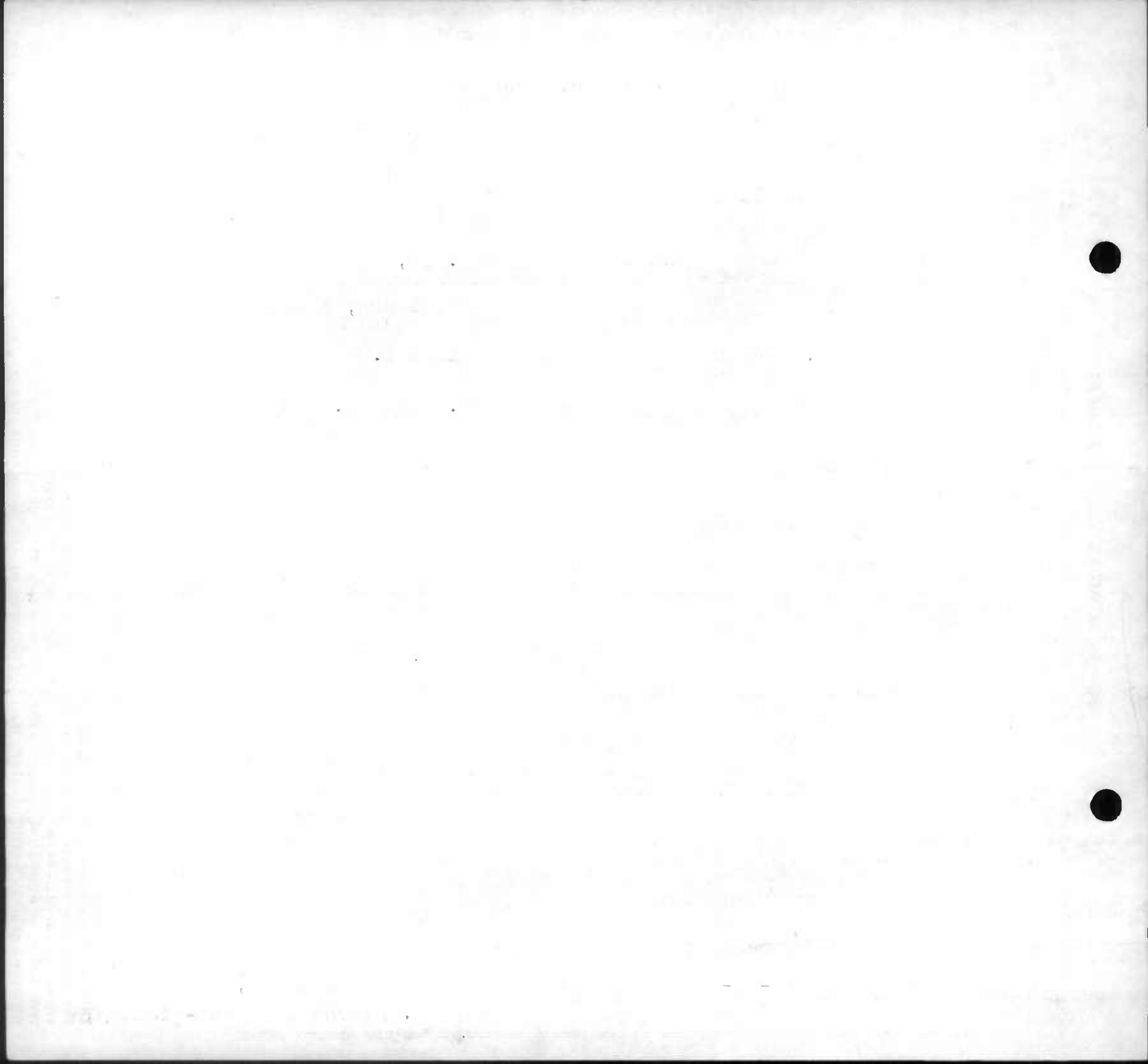
ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) <u>Encephalomalacia</u>
DUE TO
(B) <u>Generalized arteriosclerosis</u>
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<u>2+yr</u>
<u>5+yr</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>Emaciation</u> <u>6 mos</u> | | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Jan 1960</u> to <u>Dec 16 1965</u> , that (I) (we) last saw the deceased alive on <u>Dec 12 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Fredrick J. Vollmer</u> M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>12-17-65</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>D.R. FRED. VOLLMER</u> M.D. | | | | 23D. ADDRESS
<u>6100 YORK RD.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>12/18/65</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Cathedral Cem.</u> | | 24D. LOCATION (City, town, or county) (State)
<u>City</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>DEC 20 1965</u> | | 25B. NAME OF REGISTRAR
<u>DEC 20 1965</u> | | 25C. FUNERAL DIRECTOR
<u>Mitchell Wiedefeld Home</u> | | ADDRESS
<u>6500 York Rd.-21212</u> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12878 | |
|---|--------------|--|--------------------------------------|---|---|
| BIRTH NO. 65 12878 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) JAN MAUGANS Jan Marie Maugans | | 2. DATE AND HOUR OF DEATH 12/14/65 12 Noon M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
37 Mercy Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location)
1616 Thetford Road | | | |
| 5. SEX F | 6. RACE Cane | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH Jan. 30, 1956 | 9. AGE (In years last birthday) 9 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Student | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | |
| 13. FATHER'S NAME
Edwin L. Maugans | | | 14. MOTHER'S MAIDEN NAME
Alice L. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No / | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT ADDRESS
Mrs. Edwin L. Maugans | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
199.21
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) Metastatic Disease & Aneurysm
DUE TO
(B) Teratoma
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
5 Mo. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
Approx 7/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Obel Mass | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 19 65 to Dec 14 19 65, that (I) (we) last saw the deceased alive on Dec 14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Willard S. Stenley | | | | 23B. DATE SIGNED
12/14/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
M.D. Mercy Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12-16-65 | | 24C. NAME of CEMETERY or CREMATORY
Parkwood | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 25B. NAME OF REGISTRAR
Robert E. Ferguson | | 25C. FUNERAL DIRECTOR ADDRESS
John Q. Mitchell & Sons-Wiedefeld
Home 46500 Clark Road | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12879 | |
|---|------------------------------|---|---|--|--|
| BIRTH NO. 65 12879 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) Julia Elizabeth Nelson | | | 2. DATE AND HOUR OF DEATH
Dec. 15, 1965 3:50 P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
2025 Eutaw Place | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 14-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
2025 N. Eutaw Place | | |
| 5. SEX
female | 6. RACE
white | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
divorced | 8. DATE OF BIRTH
Dec. 10, 1900 | 9. AGE (In years last birthday)
65 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
self-employed | | 10B. KIND OF BUSINESS OR INDUSTRY
real estate | 11. BIRTHPLACE (State or foreign country)
Ashton, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Herbert E. Yost | | | 14. MOTHER'S MAIDEN NAME
Minerva N. Sheenebeck | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS
Wm. Wagner (executive) 2007 York Rd. | | |
| 18. 332X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cerebral thrombosis.
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Atherosclerosis. | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
unknown
23 yrs. |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
12-15-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
19-42 | 20A. AUTOPSY? (Yes or No)
no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-18 to 12-15 19 65 , that (I) (we) last saw the deceased alive on 11-18 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
George H. Yeager | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
12-17-65 |
| 23C. PHYSICIAN'S NAME (Type)
Dr. George Yeager | | | 23D. ADDRESS
Med. 675 Bldg Balto. Md 21201 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
12/18/65 | 24C. NAME OF CEMETERY or CREMATORY
St. Paul's | | 24D. LOCATION (City, town, or county) (State)
Hagerstown, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 25B. NAME OF REGISTRAR
Robert E. ... | | 25C. FUNERAL DIRECTOR ADDRESS
Mitchell-Wiedefeld Home
6500 York Road #12 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 12880 | |
|---|---------------------|---|--|---|--|---|--|
| BIRTH NO. <u>Fort Meade, MD 5 12880</u> | | | | | | | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) <u>PENNY JONES</u> | | 2. DATE AND HOUR OF DEATH
<u>DEC 15 1965</u> <u>15</u> P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>JOHNS HOPKINS HOSPITAL</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MD</u>
B. COUNTY <u>99</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>FT MEADE</u>
D. STREET ADDRESS (If rural, give location)
<u>8127A PACKARD CT.</u> | | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>NEVER MARRIED</u> | | 8. DATE OF BIRTH
<u>11/25/65</u> | 9. AGE (In years last birthday)
<u>20</u> | If Under 1 Yr. Months: Days: Hours: Min.
<u>20</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>N/A</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>none</u> | | 11. BIRTHPLACE (State or foreign country)
<u>B MD</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>DONALD G. JONES</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mavis Arlene Lawler</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>N/A</u> | | 17. INFORMANT ADDRESS
<u>Mr. Donald G. Jones, Same as #4</u> | | | |
| 18. <u>750 X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) <u>ANENCEPHALY</u>
DUE TO
(B) _____
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<u>Congenital</u> | |
| | | | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>DEC 3</u> 19 <u>65</u> to <u>DEC 15</u> 19 <u>65</u> , that (I) (we) lost saw the deceased alive on <u>DEC 15</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Norman Fost</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>DEC 15, 1965</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>NORMAN FOST</u> | | | | 23D. ADDRESS
<u>JOHNS HOPKINS HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>Dec. 17, 1965</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>ARLINGTON NATIONAL CEM.</u> | | 24D. LOCATION (City, town, or county) (State)
<u>ARLINGTON, VIRGINIA</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>DEC 20 1965</u> | | 25B. NAME OF REGISTRAR
<u>Harold S. Wade</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>Harold S. Wade, 550 Wash. Blvd., Laurel, Md</u> | | | |

REPLY JAMES

NO

PT. MARY

JOHN HONOLULU

SIXTH FLOOR

NO

11/25/62

NEVER MARRIED

W

F

B NO

DONALD G. JAMES

AMERICAN

AMERICAN

Norman Post

Norman Post
X
DEC 12 1962

DEC 12

DEC 3

DEC

DEC

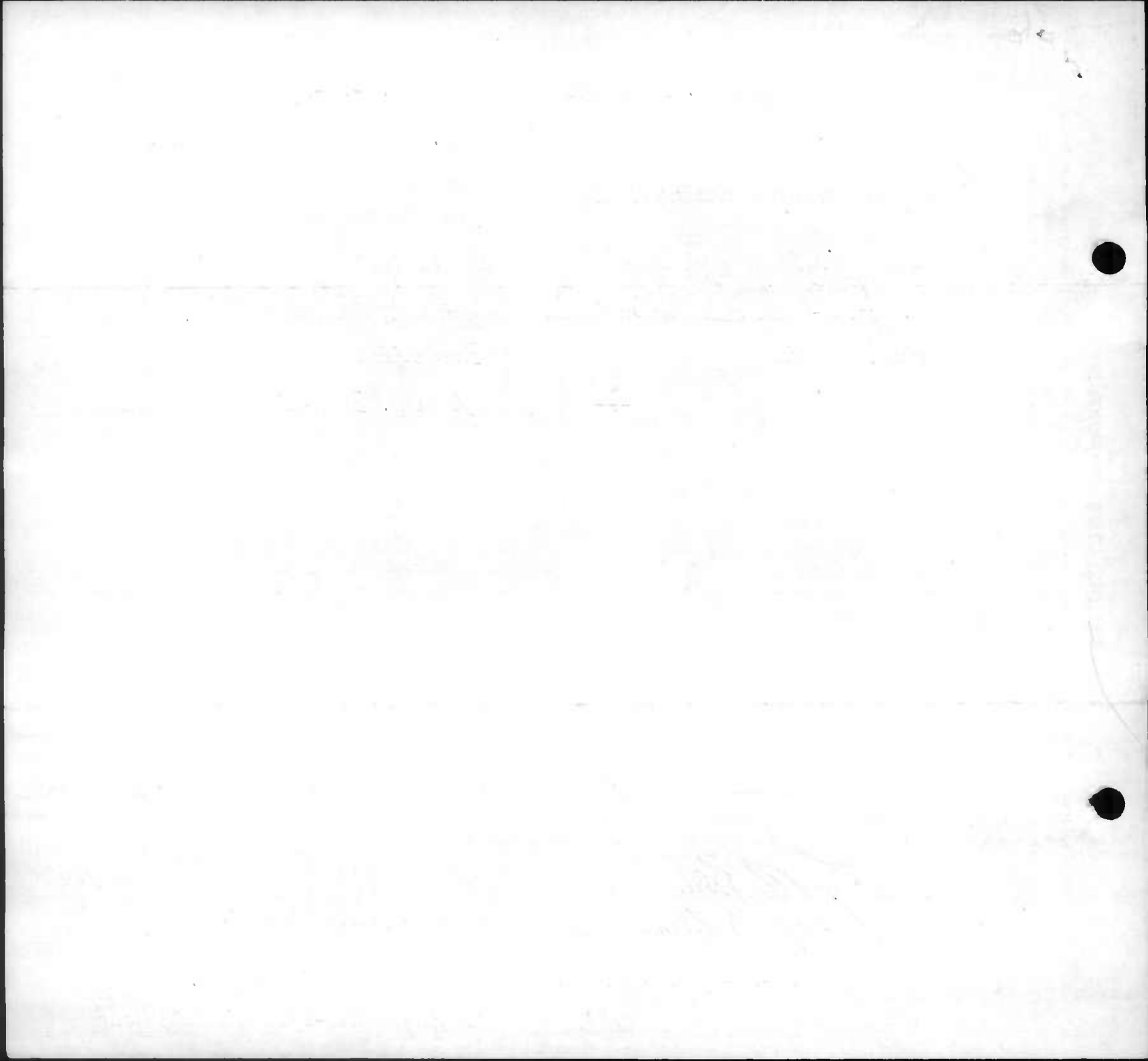
DEC 12

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|--|--|---|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>65 12881</u> | | | | | |
| BIRTH NO. <u>65 12881</u> | | | | | M.E. CASE NO. <u>65 12881</u> | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>John G. Frederick</u> | | | | | 2. DATE AND HOUR OF DEATH
<u>12-13-1965</u> <u>10:40 P.M.</u> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>Harford Gardens Nursing Home</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> | | | | | |
| 5. SEX <u>male</u> 6. RACE <u>white</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>widowed</u> | | | | | 8. DATE OF BIRTH <u>July 16, 1872</u> 9. AGE (In years last birthday) <u>93</u> | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Ret. Owner-Meat Packing business</u> | | | | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Maryland</u> | | | | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | | |
| 13. FATHER'S NAME
<u>John Frederick</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Fredericka</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | | | | 16. SOCIAL SECURITY NO.
<u>---</u> | | | | | |
| 17. INFORMANT
<u>Elmer J. Frederick</u> | | | | | ADDRESS
<u>same</u> | | | | | |
| 18. <u>450.0</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
<u>Generalized Arteriosclerosis</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Senility</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Several years</u> | | | | | |
| II | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>April</u> 19 <u>65</u> to <u>December</u> 19 <u>65</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>December 10, 1965</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (did) (<u>did not</u>) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE
<u>Loy M. Zimmerman</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | | | | 23B. DATE SIGNED
<u>12/14/65</u> | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Loy M. Zimmerman</u> | | | | | 23D. ADDRESS
<u>3202 Harford Rd Baltimore Md</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>burial</u> | | | 24B. DATE
<u>12-16-65</u> | | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Loudon Park Cemetery</u> | | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>DEC 20 1965</u> | | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | | | 25C. FUNERAL DIRECTOR
<u>Foring Byers</u> | | | ADDRESS
<u>8728 Liberty Road</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12882 | |
|---|---------------------|---|--|--|---|
| BIRTH NO. 65 12882 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Mabel Waxter | | 2. DATE AND HOUR OF DEATH
Dec. 14, 1965 9:25 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY 27-16 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
42 Sinai Hosp | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location)
2925 Edgemoor Circle | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
W | 8. DATE OF BIRTH
9/13/90 | 9. AGE (In years last birthday)
75 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
— | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Benjamin Watts | | | 14. MOTHER'S MAIDEN NAME
Lydia Rogers | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT 21208, Md ADDRESS
Richard H. Waxter, 16 Walker Ave., Pikesville | |
| 18. 420.1+1260X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Acute Myocardial Infarction | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
30 min |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Hypertensive Arteriosclerotic Cardiovascular Disease | | | (A) DUE TO | | (B) DUE TO |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Diabetes Mellitus | | | (C) DUE TO | | least 3 years |
| 19A. DATE OF OPERATION
— | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20A. AUTOPSY? (Yes or No)
no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
— | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
— | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
— | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
— | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
— | |
| 22. I certify that (I) (this hospital) attended the deceased from January 1962 to Dec. 1965 , that (I) (we) last saw the deceased alive on Dec. 7, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Terren M. Himelfarb M.D. | | | | 23B. DATE SIGNED
Dec. 14, 1965 | |
| 23C. PHYSICIAN'S NAME (Type)
TERREN M. HIMELFARB M.D. | | | | 23D. ADDRESS
Sinai Hosp. BALTO. MD. | |
| 24A. BURIAL CEMETERY, REMOVAL (Specify)
burial | | 24B. DATE
Dec. 14, 1965 | | 24C. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cem | |
| 24D. LOCATION (City, town, or county) (State)
Pikesville, Balto. Co., Md. 21208 | | 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | | |
| 25B. NAME OF REGISTRAR
John J. ... | | 25C. FUNERAL DIRECTOR
Loring Byers, 8728 Liberty Rd. Randallstown Md. 21133 ADDRESS | | | |

7

Lydia Rogers

Richard H. Rogers, Esq.

Richard H. Rogers, Esq.
Lydia Rogers

FUNERAL DIRECTOR: IMPORTANT

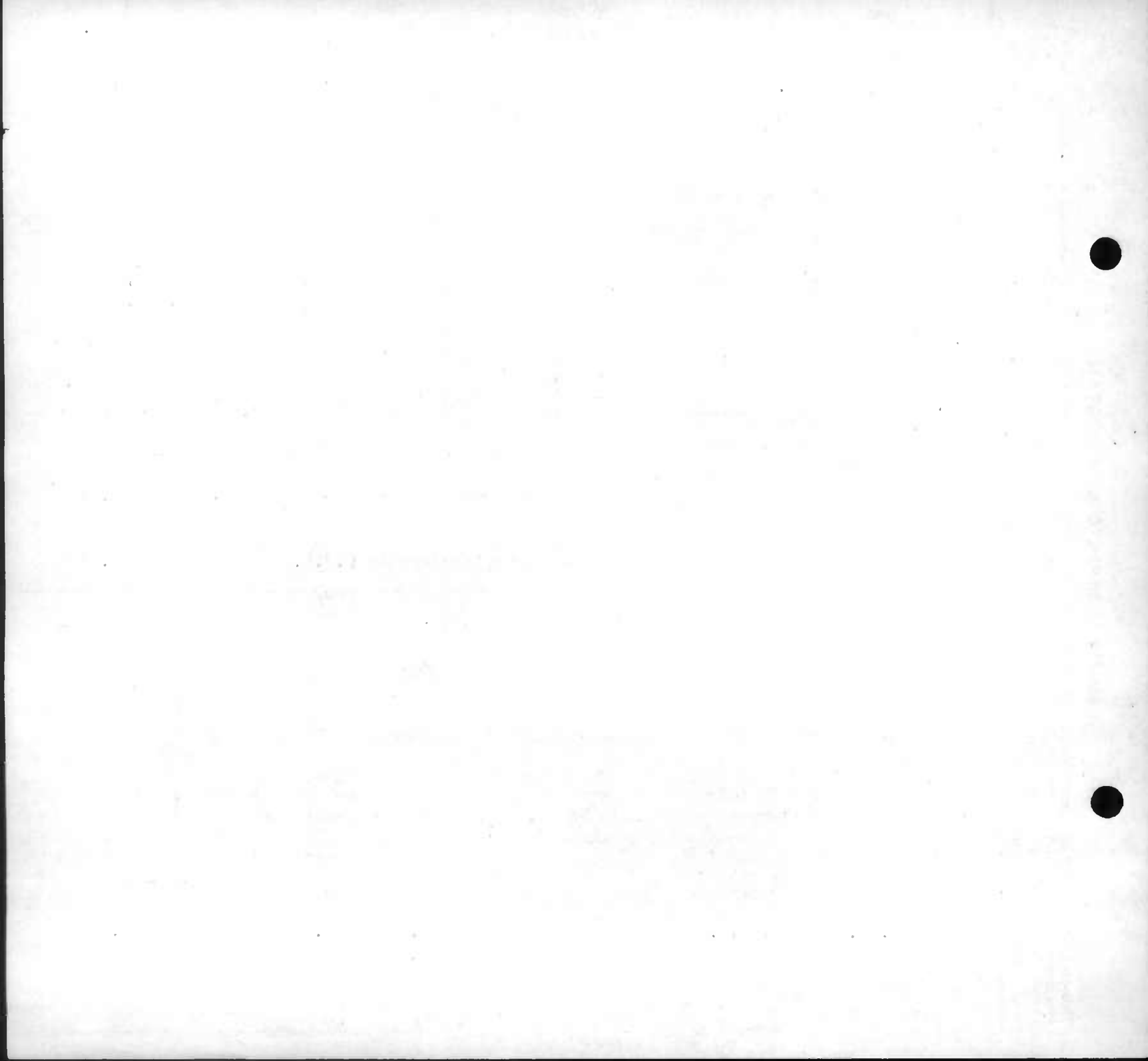
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | Registered No. 65 12883 | |
| BIRTH NO. 285 12883 | | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Anderson, Paul</i> | | | | | | 2. DATE AND HOUR OF DEATH
<i>12/12/65 11:04 A.M.</i> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>Shari Hospital</i> | | | | | | A. STATE <i>MD</i> B. COUNTY <i>2719</i> | | | | | |
| (If not in hospital or institution, give street address or location) | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | | | | | |
| D. STREET ADDRESS (If rural, give location)
<i>2608 Manhattan Ave</i> | | | | | | | | | | | |
| 5. SEX
<i>M</i> | | 6. RACE
<i>W</i> | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Married</i> | | 8. DATE OF BIRTH
<i>5/8/1907</i> | | 9. AGE (In years last birthday)
<i>58</i> | | 10. If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Floor Sander owner</i> | | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore</i> | | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | | | | | | | | | |
| 13. FATHER'S NAME
<i>John Anderson</i> | | | | | | 14. MOTHER'S MAIDEN NAME
<i>Pauline Neilson</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | | | | | 16. SOCIAL SECURITY NO.
<i>215-22-5068</i> | | 17. INFORMANT
<i>2122455 Mrs. Helen T. Anderson, 2608 Manhattan Ave</i> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<i>CHF</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>6 years</i> | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION
<i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No)
<i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<i>Yes</i> | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/12</i> 19 <i>65</i> to <i>12/12</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>12/12</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
<i>Leonard J. Hertzberg</i> | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<i>12/12/65</i> | | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Leonard J. Hertzberg</i> | | | | | | 23D. ADDRESS
<i>Shari Hospital Balt. Md</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>burial</i> | | 24B. DATE
<i>12-15-65</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Lorraine Plk Cem.</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Windsor Mill Rd. Balt. Co. Md</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>DEC 20 1965</i> | | 25B. NAME OF REGISTRAR
<i>Robert J. ...</i> | | | | 25C. FUNERAL DIRECTOR ADDRESS
<i>Loring Byers, 8728 Liberty Rd, 21133.</i> | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|---------|--|------------------|--|--|
| 65 12884 | | CERTIFICATE OF DEATH | | 65 12884 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Edna V. Mac Quarrie | | Dec 15, 1965 8:45 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | Maryland | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| Union Memorial Hospital | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 4312 Falls Road | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min. |
| F | White | Widowed | 1/22/85 | 80 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | | | Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Ebeneser Stewart | | Margaret Bloss | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| N/A | | 214-01-7019A | | Harry Stewart 4312 Falls Rd, Balto, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | Acute coronary thrombosis 2-4 minutes | |
| | | (B) DUE TO | | Coronary artery atherosclerosis 25 yrs. + | |
| | | (C) DUE TO | | Arteriosclerotic C.V.D. 25 yrs. + | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Chronic uremia | | 6 months +- | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| No | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (did not) attended the deceased from 19 50 to present time 19 65, and that (I) (was) lost saw the deceased alive on December 4, 19 65, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. PHYSICIAN'S NAME (Type) | | 23C. ADDRESS | |
|  | | R. V. Rangle, M.D. | | 2938 St. Paul St., Baltimore 18, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 12/18/65 | | Loudon Park Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| DEC 20 1965 | | R. V. Rangle, M.D. | | Frank St. Seitz | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12885 | |
|--|--|---|--|--|--|
| BIRTH NO. 65 12885 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Borleske Lena | | 2. DATE AND HOUR OF DEATH 13-Dec-65 6 45 PM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | MARYLAND GENERAL Hospital | | MARYLAND BALTIMORE CITY | |
| 5. SEX Female | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | |
| 8. DATE OF BIRTH 3-21-84 | | 9. AGE (In years lost birthday) 81 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | |
| 11. BIRTHPLACE (State or foreign country) Hungary | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Unknown | |
| 14. MOTHER'S MAIDEN NAME Unknown | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) No | | 16. SOCIAL SECURITY NO. 216-01-4380 | |
| 17. INFORMANT William Borloske | | ADDRESS ST PATRICKS Rd Balto. | | 18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | |
| (A) DUE TO Chronic heart failure - 3 years - | | (B) DUE TO | | (C) Arteriosclerotic Cardiovascular disease | |
| INTERVAL BETWEEN ONSET AND DEATH | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 19A. DATE OF OPERATION | |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (M) (this hospital) attended the deceased from 3-Dec-65 to 13-Dec-65, that (M) (we) last saw the deceased alive on 13-Dec-65 and that in (M) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (M) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE T.C. Cullis | | 23B. DATE SIGNED 13-Dec-65 | |
| 23C. PHYSICIAN'S NAME (Type) T.C. Cullis | | 23D. ADDRESS Maryland General Hospital | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | |
| 24B. DATE 12/18/65 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemers | | 24D. LOCATION Baltimore 4206 - Md | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 20 1965 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| 25D. DATE REC'D BY HEALTH DEPT. DEC 20 1965 | | 25E. NAME OF REGISTRAR | | 25F. FUNERAL DIRECTOR | |

Shakespeare

SAB-45 -43-27

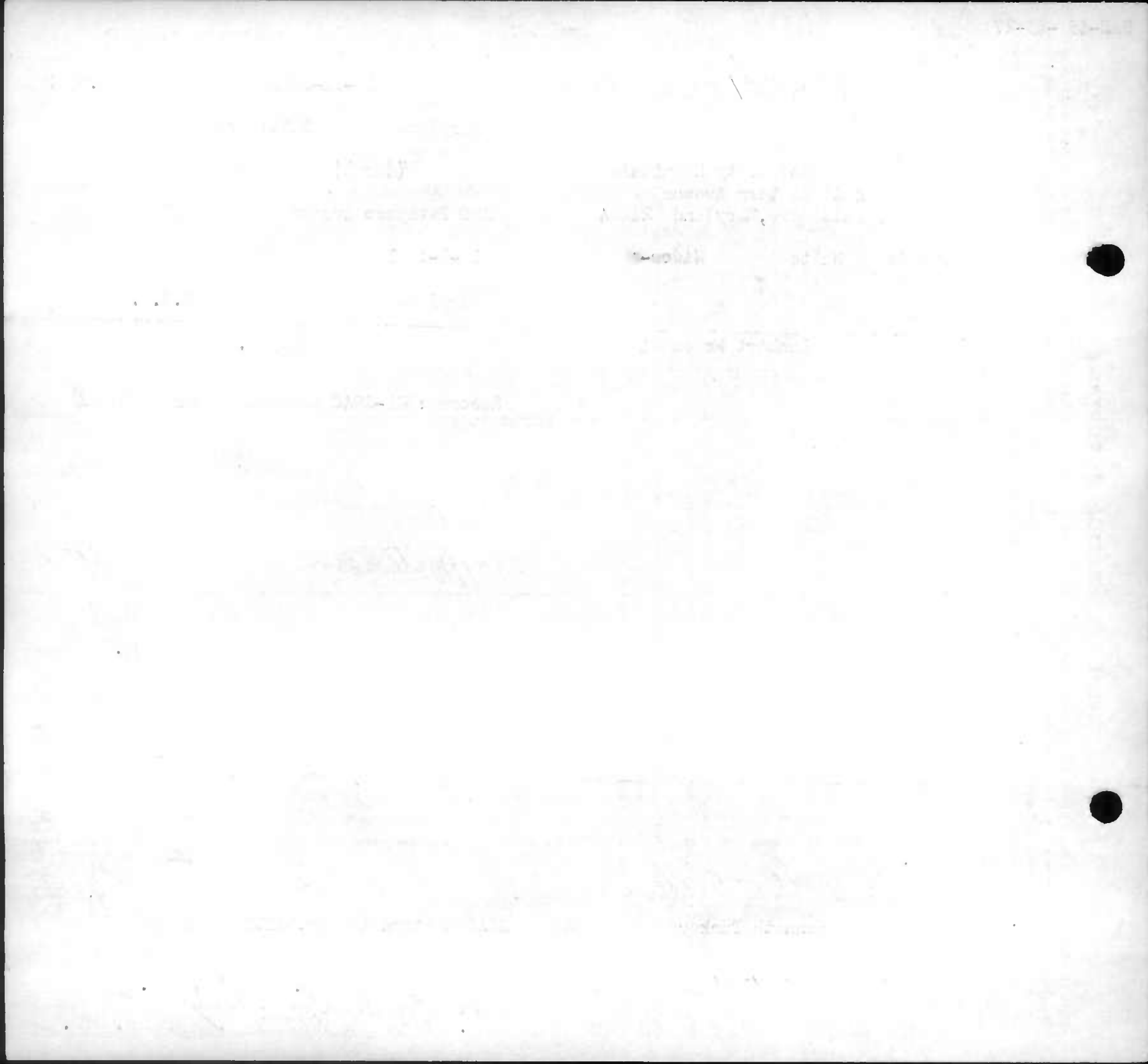
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|--------------------------------------|--|--|
| BIRTH NO.
65 12886 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 65 12886 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print)
MARY PERKINS | | 2. DATE AND HOUR OF DEATH
12-14-1965 11.55 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
#(RURAL) DUNDALK 33-00
D. STREET ADDRESS (If rural, give location)
220 Patapsco Avenue 21222 | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
Widow | 8. DATE OF BIRTH
11-1-1881 | 9. AGE (In years last birthday)
84 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Lambert McDonnal | | 14. MOTHER'S MAIDEN NAME
Mary E. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT ADDRESS
Records: BCH-4940 Eastern Avenue 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Aspiration pneumonia | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
2 days | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) CVA. | | 2 days | |
| | | (C) Hypertension | | 12-15 yrs. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from Dec. 12 19 65 to Dec. 14 19 65 , that (2) (we) last saw the deceased alive on Dec. 14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Kenneth Tucker</i> | | | | 23B. DATE SIGNED
Dec. 14, 1965 | |
| 23C. PHYSICIAN'S NAME (Type)
Kenneth Tucker | | 23D. ADDRESS
M.D. 4940 Eastern Avenue, Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
12/18/65 | | 24C. NAME of CEMETERY or CREMATORY
OAK MAWN | |
| 24D. LOCATION
BALTO. COUNTY, MD. | | 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | | |
| 25B. NAME OF REGISTRAR
W. Brooks & Radley | | 25C. FUNERAL DIRECTOR ADDRESS
DUNDALK, MD. | | | |



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BARBARA M. HEISTERMAN

2. DATE AND HOUR PRONOUNCED DEAD

December 16, 1965 8:00 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

40 St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6607 Eastern Parkway

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

Jan. 26, 1913

9. AGE (In years
last birthday)

XXX 52

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

SALES LADY

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

LOUIS HIRSHAUER

14. MOTHER'S MAIDEN NAME

MARY

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

216-14-3992

17. INFORMANT

ADDRESS

CARROLL B. HEISTERMAN, 6607 EASTERN PARKWAY

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Massive Subarachnoid Hemorrhage
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Rupture of Congenital Aneurysm.
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
12/17/6523A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

12/22/65

23C. NAME OF CEMETERY or CREMATORY

LOUDON PARK CEMETERY

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

DEC 20 1965

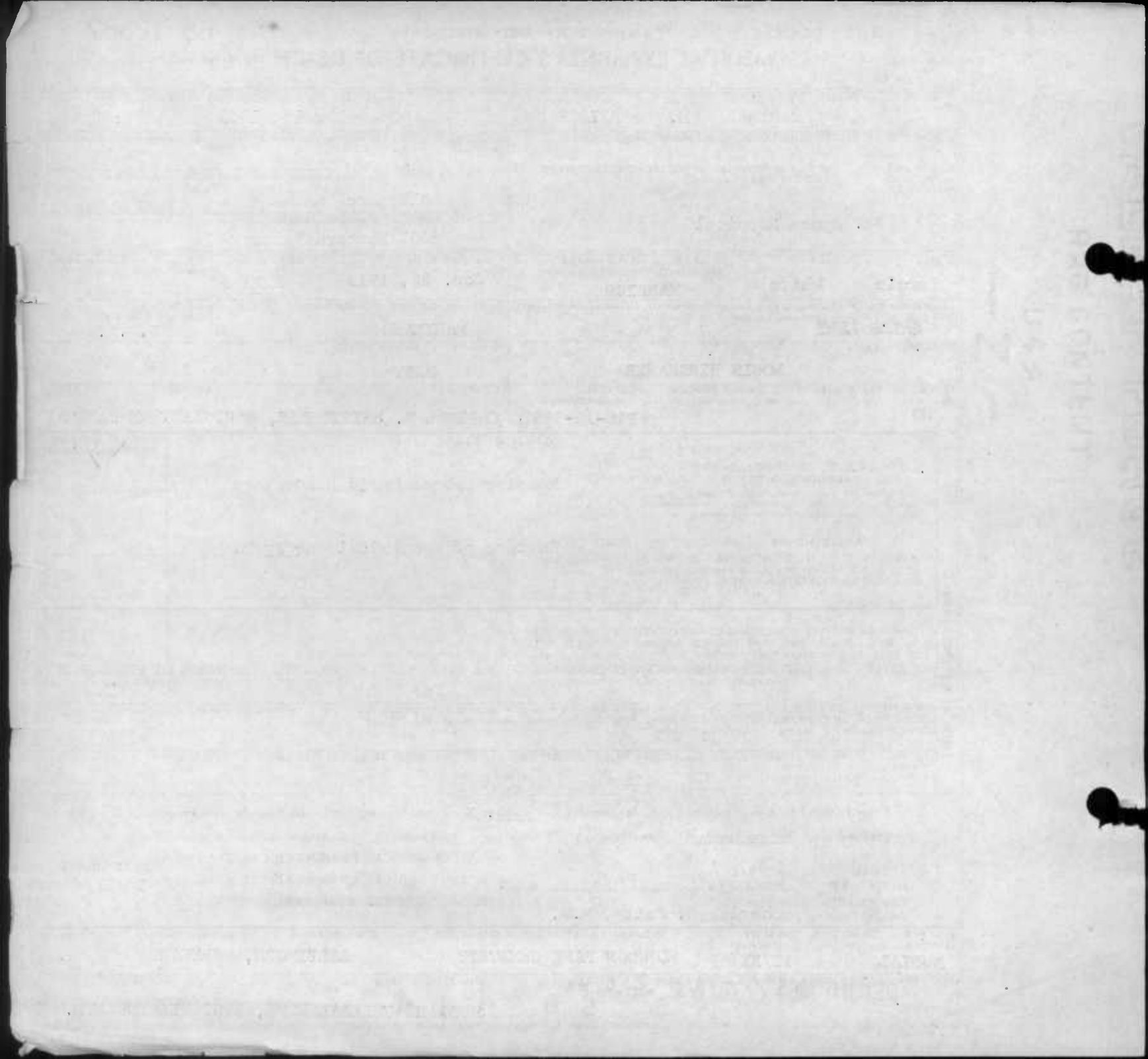
24B. NAME OF REGISTRAR

1 9 6 5 0 0

24C. FUNERAL DIRECTOR

ADDRESS

HUBBARD FUNERAL HOME, 4107 WILKENS AVE. #29



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|------------------------------------|---|---|
| BIRTH NO.
65 12888 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 65 12888 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>THERESA MARY KLUMPP</i> | | 2. DATE AND HOUR OF DEATH
<i>12-17-65</i> <i>4:00 A. M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE <i>MARYLAND</i>
B. COUNTY <i>Carroll</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>SYKESVILLE</i> <i>56-00</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>UNIVERSITY HOSPITAL</i> | | D. STREET ADDRESS (If rural, give location)
<i>SPRINGFIELD STATE HOSPITAL</i> | | | |
| 5. SEX
<i>FEMALE</i> | 6. RACE
<i>WHITE</i> | 7. MARRIED, NEVER MARRIED
<i>WIDOWED, DIVORCED (specify)</i>
<i>DIVORCED</i> | 8. DATE OF BIRTH
<i>10-1-17</i> | 9. AGE (In years, first birthday)
<i>48</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>FACTORY WORKER</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>X</i> | | 11. BIRTHPLACE (State or foreign country)
<i>HAZLETON, PENNSYLVANIA</i> | |
| 13. FATHER'S NAME
<i>Nicholas Boletting</i> | | 14. MOTHER'S MAIDEN NAME
<i>Amilla S. Taro</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>Unknown</i> | | 16. SOCIAL SECURITY NO.
<i>Unknown</i> | | 17. INFORMANT
<i>CHART</i> ADDRESS
<i>MRS. ANNA CUTAIAR, 814 FRANCIS AVE.</i> | |
| 18. <i>191.9</i> I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <i>Sepsis</i>
DUE TO
(B) <i>Pelvic abscess</i>
DUE TO
(C) <i>Squamous Cell Carcinoma of the Cervix</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<i>Pneumonia</i> | | 19A. DATE OF OPERATION
<i>11-18-65</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Pelvic abscess</i> | |
| 19A. DATE OF OPERATION
<i>11-18-65</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Pelvic abscess</i> | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
1 (Month) 1 (Day) 1 (Year) 1 (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from <i>11-12</i> 19 <i>65</i> to <i>12-17</i> 19 <i>65</i> , that (we) last saw the deceased alive on <i>12-17</i> 19 <i>65</i> and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>James F. Smith</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>12-17-65</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>James F. Smith</i> | | 23D. ADDRESS
M.D. <i>University Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 24B. DATE
<i>12/20/65</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>MOST PRECIOUS BLOOD CEMETERY</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 24B. DATE
<i>12/20/65</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>MOST PRECIOUS BLOOD CEMETERY</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>HAZLETON, PENNSYLVANIA</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>DEC 20 1965</i> | | | |
| 25B. NAME OF REGISTRAR
<i>R. A. E. F. D. M.</i> | | 25C. FUNERAL DIRECTOR
<i>HUBBARD FUNERAL HOME, 4107 WILKENS AVE. 21229</i> | | | |

10

Refuse to

[Signature]

James

Adrian Brown

45-14

53-62

Hand F new

University of Toronto

65 12889

BALTIMORE CITY HEALTH DEPARTMENT

65 12889

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDWIN F. MOEBUS

2. DATE AND HOUR PRONOUNCED DEAD

December 16, 1965 6:05 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2-24-66

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Ohio

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Hamilton

D. STREET ADDRESS (If rural, give location)

616 Marcia Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

MAY 17, 1910

9. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

HAMILTON, OHIO

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

EDWARD C. MOEBUS

14. MOTHER'S MAIDEN NAME

ANNA LOUISE SMITH

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

275-10-5544

17. INFORMANT

ADDRESS

MISS MILDRED MOEBUS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Rupture of Heart and Other Traumatic Injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Confused Mental State
DUE TO

(C) Thrombus of Left Common Carotid Artery

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Hospital

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Johns Hopkins Hospital

21D. TIME
OF INJURY
(APPROX.)

12

16

'65

P

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fall from 3d floor window.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
12/17/6523A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

12/20/65

23C. NAME of CEMETERY or CREMATORY

GREENWOOD CEMETERY

23D. LOCATION

HAMILTON,

OHIO

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 20 1965

HUBBARD FUNERAL HOME, 4107 WILKENS AVE. # 29

VALLEY FORGE

RECEIVED

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | |
|---|--|--------------|--|---|---|-----------------------------|--|---------------------------------------|--|--|--|-----------------------------|--|--|--|--|--|--|--|
| BIRTH NO. 65 12890 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 12890 | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Erna Marie Fasano | | | | | 2. DATE AND HOUR OF DEATH
Dec. 17, 1965 12: 27 A.M. | | | | | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
US Public Health Service Hospital
Wyman Pk. Drive & 31st St. | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pa.
B. COUNTY V-35
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Mt. Pleasant
D. STREET ADDRESS (If rural, give location)
Star Route (Westmoreland Co) | | | | | | | | | | | | | | |
| 5. SEX
F | | 6. RACE
W | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | | 8. DATE OF BIRTH
4/21/12 | | 9. AGE (In years last birthday)
53 | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country)
Pa. | | | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | | |
| 13. FATHER'S NAME
Henry Henkel | | | | | 14. MOTHER'S MAIDEN NAME
Bertha Swain | | | | | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | | 16. SOCIAL SECURITY NO.
287-03-9514 | | | | | 17. INFORMANT
Records- US PHS Hospital, Balto, Md. | | | | | ADDRESS | | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
Cachexia
(A) DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Carcinoma of the left kidney
(B) DUE TO
with widespread metastases
(C) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Months
Months | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION
2 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No)
Yes | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov. 12 19 65 to Dec. 17 19 65, that (I) (we) last saw the deceased alive on Dec. 17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE
James M. Weaver | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED
12/17/65 | | | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type)
James M. Weaver, Medical Director | | | | | M.D. 23D. ADDRESS
US PHS Hospital, Balto, 11, Md. | | | | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | | | | 24B. DATE
12/20/65 | | | | | 24C. NAME OF CEMETERY OR CREMATORY
ST. JOSEPH'S CEMETERY | | | | | 24D. LOCATION (City, town, or county) (State)
MT. PLEASANT, PA. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | | | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | | | | 25C. FUNERAL DIRECTOR
HUBBARD FUNERAL HOME, 4107 WILKENS AVE. # 29 | | | | | ADDRESS | | | | |

THE UNITED STATES OF AMERICA
DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

Washington, D. C. 20535
Date: [illegible]
To: [illegible]

Re: [illegible]
[illegible]

[illegible]
[illegible]

[illegible]
[illegible]

[illegible]
[illegible]

[illegible]
[illegible]

[illegible]
[illegible]

[illegible]
[illegible]

[illegible]
[illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12891 | |
|---|---------------------|---|--|--|---|
| BIRTH NO. 65 12891 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. 65 12891 | | 2. DATE AND HOUR OF DEATH
Dec 15, 1965 9:30 A.M. | | | |
| 1. NAME OF DECEASED
(Type or Print) Disney Jackson | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 15-06 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1613 Longwood St. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
1613 N. Longwood st. | | | |
| 5. SEX
m | 6. RACE
C | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
M | 8. DATE OF BIRTH
Nov 1, 1898 | 9. AGE (In years last birthday)
67 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Ga. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A | | 13. FATHER'S NAME
William Jackson | | 14. MOTHER'S MAIDEN NAME
Ella | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
214-01-8071 | | 17. INFORMANT ADDRESS
Daisy Jackson 1613 Longwood St. | |
| 18. 331X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cerebral hemorrhage | | CAUSE OF DEATH
(A) DUE TO
Cerebral hemorrhage
(B) DUE TO Arterio-sclerosis and 2 previous attacks of cerebral hemorrhage
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
Immediately
18 months
Signs | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
II
Gastric ulcer | | | | | |
| 19A. DATE OF OPERATION
8 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1, 1964 to 12-15-1965 , that (I) (we) last saw the deceased alive on 12-5-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Frank A. Saunders | | | | 23B. DATE SIGNED
12-17-65 | |
| 23C. PHYSICIAN'S NAME (Type)
FRANK A. SAUNDERS | | | | 23D. ADDRESS
1029 N. Street St. Baltimore 21217 Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12/18/65 | | 24C. NAME OF CEMETERY or CREMATORY
Carver Mem. Park | |
| 24D. LOCATION (City, town, or county) (State)
Laurel Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | | |
| 25B. NAME OF REGISTRAR
Geo. G. Kelson | | 25C. FUNERAL DIRECTOR ADDRESS
1348 N. Calhoun st. | | | |

my friend

My dear Mr. [Name]

Dear Sir

I am very pleased to hear from you

and hope you are well

Yours truly

Yours

Very respectfully

[Signature]

[Name]

Enclosed find [Amount]

BIRTH NO.

65 12892

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 12892

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CALVIN CREWS

2. DATE AND HOUR PRONOUNCED DEAD

12. 10. 65

1. 20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

PROVIDENT HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

MARYLAND

B. COUNTY

C. CITY (If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

1521 MYRTLE AVENUE

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Aug 4, 1894

9. AGE (In years
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George Crews

14. MOTHER'S MAIDEN NAME

Emily Barksdale

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes WWI

16. SOCIAL
SECURITY NO.

212-03-4872

17. INFORMANT

ADDRESS

Thomas S. Crews 1328 Mount St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR
DISEASE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
12.11.6523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-21-65

23C. NAME of CEMETERY or CREMATORY

Balt. Natl. Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 20 1965

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

ADDRESS

George A. Klein 1348 N. Calhoun St.

VALLEY RIDGE

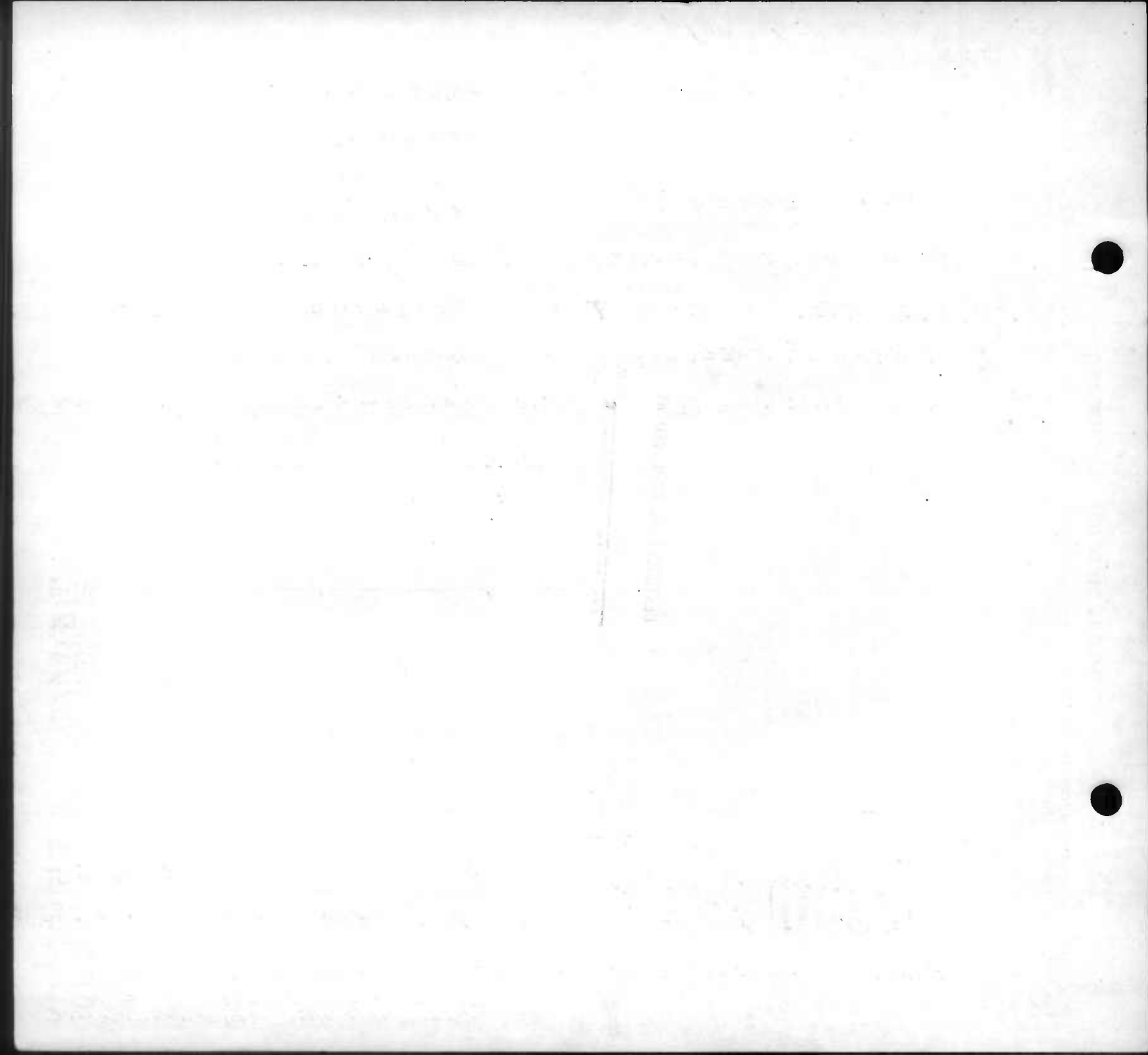
MEMORANDUM

28

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|-------------------------|--|--|--|--|--|-----------------------|
| BIRTH NO. 65 12893 | | CITY OF BALTIMORE HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 12893 | |
| 1. NAME OF DECEASED
(Type or Print) NORMAN ELMER FREEBURGER, JR. | | | | 2. DATE AND HOUR OF DEATH
DEC. 16, 1965 12:30 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE
MARYLAND | | B. COUNTY
21-02 | |
| 904 S. CAREY ST. | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| D. STREET ADDRESS (If rural, give location)
904 S. CAREY ST. | | | | | | | |
| 5. SEX
MALE | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
JUNE 25, 1921 | 9. AGE (In years last birthday)
44 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
PIPE FITTER | | 10B. KIND OF BUSINESS OR INDUSTRY
CONST. GUARD MARINE | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
NORMAN E. FREEBURGER, SR. | | | | 14. MOTHER'S MAIDEN NAME
HARRIET V. SEHMAN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
YES World War II BY | | 16. SOCIAL SECURITY NO.
238-07-5710 | | 17. INFORMANT
FRANCIS A. FREEBURGER | | ADDRESS
904 S. CAREY ST. | |
| 18. 4-20-11 I | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease or injury or complication which caused death.)
Coronary artery occlusion Sudden | | | | (A) DUE TO | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Atherosclerotic cardio-vascular disease | | | | (B) DUE TO | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (C) | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 26, 1963 to Dec. 16, 1965 , that (I) was last saw the deceased alive on Oct. 21, 1965 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Harry A. Knipp | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
12-16-65 | |
| 23C. PHYSICIAN'S NAME (Type)
HARRY A. KNIPP | | | | 23D. ADDRESS
4116 Edmondson Ave. Balt 29th | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
12-20-65 | | 24C. NAME OF CEMETERY or CREMATORY
BALTIMORE NATIONAL | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE MD | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 25B. NAME OF REGISTRAR
John H. Miller | | 25C. FUNERAL DIRECTOR
Geo. L. Schwab | | ADDRESS
Funeral Home 2101 Thelma Ave. | |

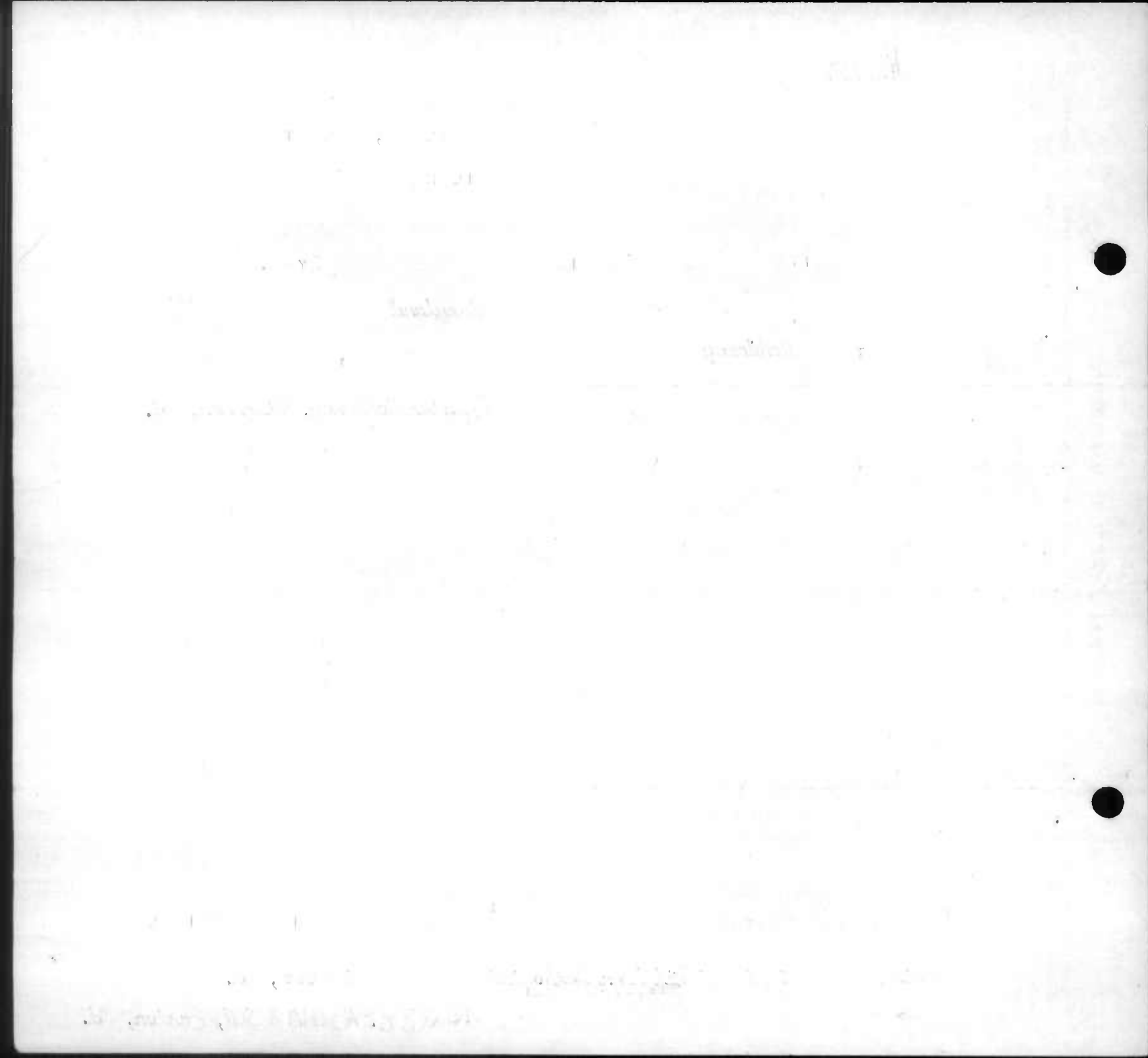


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. <u>65 12894</u> | |
|--|-------------------------|---|--|---|--|--|--|
| BIRTH NO. <u>Talbot Co., Md. 65 12894</u> | | | | DATE AND HOUR OF DEATH
<u>12/15/65</u> <u>6 05</u> P.M. | | | |
| M.E. CASE NO. <u>DIANNE HADDAWAY</u> | | | | 1. NAME OF DECEASED
(Type or Print) | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>23 JOHNS HOPKINS HOSPITAL.</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MARYLAND, TALBOT</u>
B. COUNTY <u>TILGHMAN</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>10-20</u>
D. STREET ADDRESS (If rural, give location) | | | |
| 5. SEX
<u>F.</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>NEVER MARRIED</u> | 8. DATE OF BIRTH
<u>6-15-63</u> | 9. AGE (In years last birthday)
<u>2 YRS.</u> | If Under 1 Yr. Months Days Hours Min.
If Under 24 Hrs. Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 13. FATHER'S NAME
<u>CHESTER Haddaway</u> | | | 14. MOTHER'S MAIDEN NAME
<u>CUMMINGS, CONSTANCE</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Chester Haddaway, Tilghman, Md.</u> | | ADDRESS |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<u>155.01</u>
<u>Hypovolemia</u> | | | | CAUSE OF DEATH
(A) DUE TO
<u>Intraabdominal hemorrhage</u>
(B) DUE TO
<u>Hepctoma</u>
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
<u>12 hours</u>
<u>24 hours</u>
<u>7 mo.</u> | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>15 Dec 65</u> 19 to 19, that (I) (we) last saw the deceased alive on <u>15 Dec 65</u> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Charles Morehead</u> M.D. | | | | 23B. DATE SIGNED
<u>15 Dec 65</u> | | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>CHARLES MOREHEAD</u> | | | | 23D. ADDRESS
M.D. <u>THE JOHNS HOPKINS HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>12/18/65</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Tilghman, Methodist</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Tilghman, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>DEC 20 1965</u> | | | | 25C. FUNERAL DIRECTOR
<u>MURGE E. NEUNAM & SON, Easton, Md.</u> | | | |

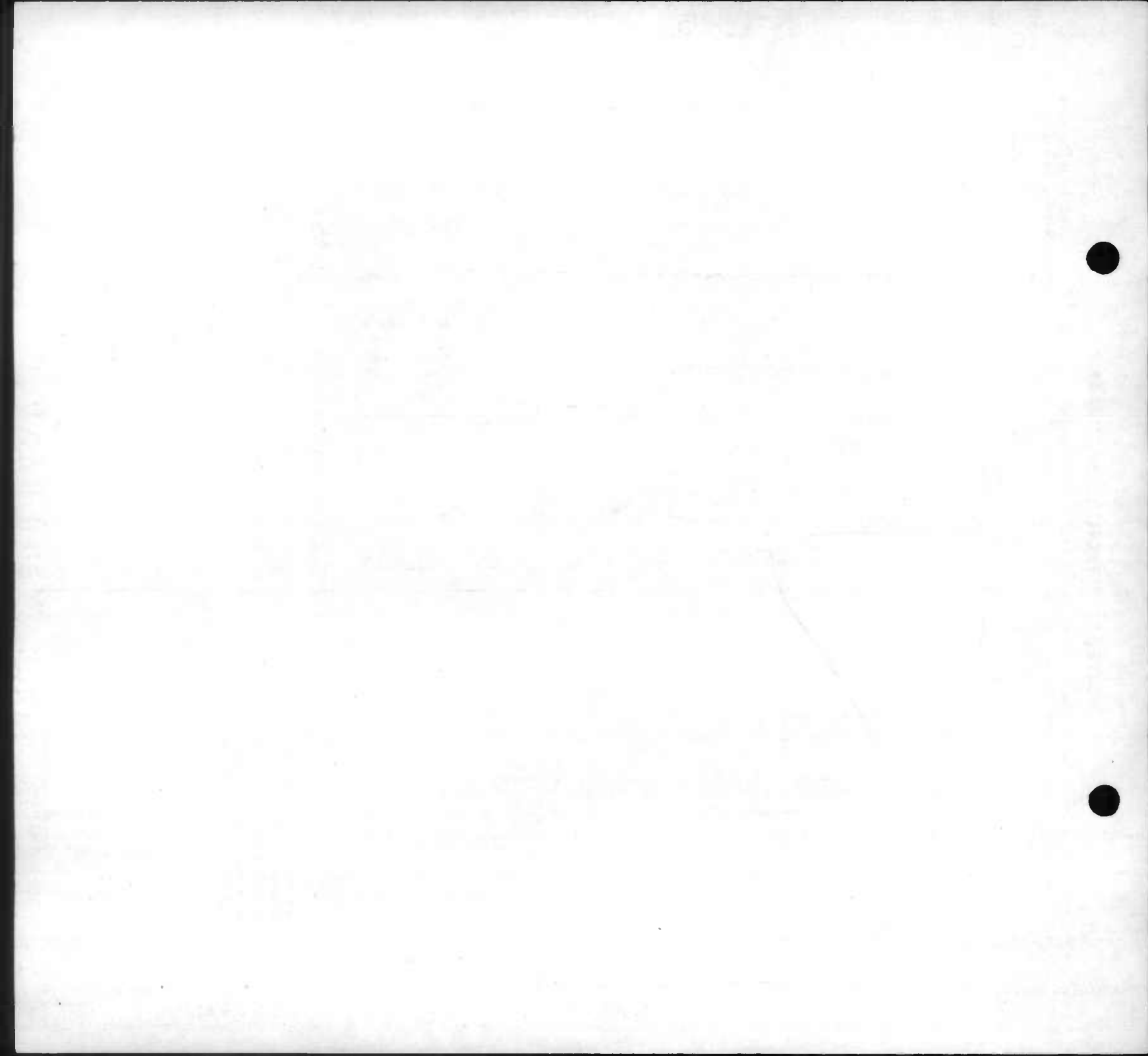


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | |
|---|--|---------------------|---|--|--|--|---------------------------------|---|--|--|--|------------------------------|--|--|----------------------------------|--|
| 65 12895 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 12895 | | | | | | |
| BIRTH NO. 65 12895 | | | | | | | | | | M.E. CASE NO. | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Thornhill, Catherine Edna</i> | | | | | | | | | | 2. DATE AND HOUR OF DEATH
<i>Dec 14, 1965 1 3¹⁵ A M.</i> | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>University Hospital
Baltimore Maryland</i> | | | | | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Joppa 5300</i> | | | | | | |
| D. STREET ADDRESS (If rural, give location)
<i>2915 Woods End Drive</i> | | | | | | | | | | | | | | | | |
| 5. SEX
<i>F</i> | | 6. RACE
<i>W</i> | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Married</i> | | 8. DATE OF BIRTH
<i>3/9/07</i> | | 9. AGE (In years last birthday)
<i>58</i> | | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Retired Airborne Instruments Lab</i> | | | | | 11. BIRTHPLACE (State or foreign country)
<i>N. York</i> | | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | |
| 13. FATHER'S NAME
<i>Frank Hinnenkamp</i> | | | | | | | | | | 14. MOTHER'S MAIDEN NAME
<i>Marie Kahland</i> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | | | | 16. SOCIAL SECURITY NO.
<i>081-09-8189H A</i> | | 17. INFORMANT
<i>Patient</i> | | | | | ADDRESS | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<i>410X I</i> | | | | | | | | | | CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | (A) <i>Congestive Heart Failure</i>
DUE TO | | | | | <i>4 years</i> | |
| | | | | | | | | | | (B) <i>Rheumatic Heart Disease</i>
DUE TO | | | | | <i>40 years</i> | |
| | | | | | | | | | | (C) <i>(Mitral Stenosis)</i> | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Nov 11</i> 19 <i>65</i> to <i>Dec 14</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>Dec 14</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE
<i>Harold C Standiford</i> | | | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED
<i>12/14/65</i> | | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Burial</i> | | | | | | | | | | 23D. ADDRESS
M.D. | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | 24B. DATE
<i>12-16-65</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Parkwood Cemetery</i> | | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore Co. Md.</i> | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>DEC 20 1965</i> | | | | | 25B. NAME OF REGISTRAR
<i>John E. Fisher</i> | | | | | 25C. FUNERAL DIRECTOR
<i>John E. Fisher</i> | | | | | | |
| ADDRESS (36)
<i>Home 7461 Belair Road</i> | | | | | | | | | | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|--|---|--|
| BIRTH NO.
65 12896 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 65 12896 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) <i>Gamble, Louvenia</i> | | | 2. DATE AND HOUR OF DEATH
12-18-65 10:00 A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>34 Bon Secours Hospital</i> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 20-02</i>
D. STREET ADDRESS (If rural, give location) <i>116 N. Smallwood St.</i> | | |
| 5. SEX <i>F</i> | 6. RACE <i>C</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>1-5-1904</i> | 9. AGE (In years last birthday) <i>61</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Selma Alabama</i> | |
| 13. FATHER'S NAME <i>Louis Bates</i> | | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>unknown</i> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
<i>John Gamble - 116 N. Smallwood St.</i> |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
I. <i>442X1</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<i>Hypertensive Cardio-renal disease</i> | | | INTERVAL BETWEEN ONSET AND DEATH
<i>YEARS</i> | | |
| II. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO
(C) DUE TO | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>21</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i> | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that <i>(H)</i> (this hospital) attended the deceased from <i>12-14</i> 19 <i>65</i> to <i>12-18</i> 19 <i>65</i> , that <i>(H)</i> (we) last saw the deceased alive on <i>12-18</i> 19 <i>65</i> and that in <i>(my)</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>(H)</i> (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>Octavio A. Ruiz</i> | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>12-18-65</i> |
| 23C. PHYSICIAN'S NAME (Type) <i>Octavio A. Ruiz</i> | | | 23D. ADDRESS <i>Bon Secours Hosp.</i> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>12-21-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Memorial Park</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>DEC 20 1965</i> | | | |
| 25B. NAME OF REGISTRAR <i>Charles R. Law</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>802 Madison Ave.</i> | | | |

10) PDP1-2-1

Ref - Ref. 2102

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12897 | |
|--|-------------------------|--|--|--|---|
| BIRTH NO. 65 12897 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) REDMOND HURLEY | | 2. DATE AND HOUR OF DEATH
12-16-65 4 45 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY 13-03 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
ON TRANSIT TO HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location)
1511 CLIFTON AVE. | | | |
| 5. SEX
MALE | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
1-6-1897 | 9. AGE (In years last birthday)
68 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Painter | | 10B. KIND OF BUSINESS OR INDUSTRY
— | 11. BIRTHPLACE (State or foreign country)
— Va | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Palmer Redmond | | | 14. MOTHER'S MAIDEN NAME
Lucy Warring | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
220 82 7019 | 17. INFORMANT ADDRESS
Dorothy Redmond 1511 Clifton Ave | | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
MYOCARDIAL INFARCTION | | CAUSE OF DEATH
(A) DUE TO
MYOCARDIAL INFARCTION | | INTERVAL BETWEEN ONSET AND DEATH
MINUTES | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
SELECTED ARTERIOVASCULAR DISEASE | | (B) DUE TO
ARTERIOVASCULAR DISEASE | | YEARS | |
| (C) _____ | | | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
POSSIBLE "ASTHMA" | | NOT KNOWN | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from 8-9 1965 to 9-1 1965 , that (I) <u>(we)</u> last saw the deceased alive on 9-1 1965 and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (We) <u>(did)</u> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
W.A. Christmas | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
12-16-65 | |
| 23C. PHYSICIAN'S NAME (Type)
W.A. CHRISTMAS | | 23D. ADDRESS
SINAI HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12/20/65 | | 24C. NAME OF CEMETERY or CREMATORY
Arbutus Mem. Pk | |
| 24D. LOCATION (City, town, or county) (State)
Arbutus, Md | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 25B. NAME OF REGISTRAR
Joseph B. Jackson | | 25C. FUNERAL DIRECTOR ADDRESS
1304 N. Central Ave | |

RECEIVED
JAN 10 1960

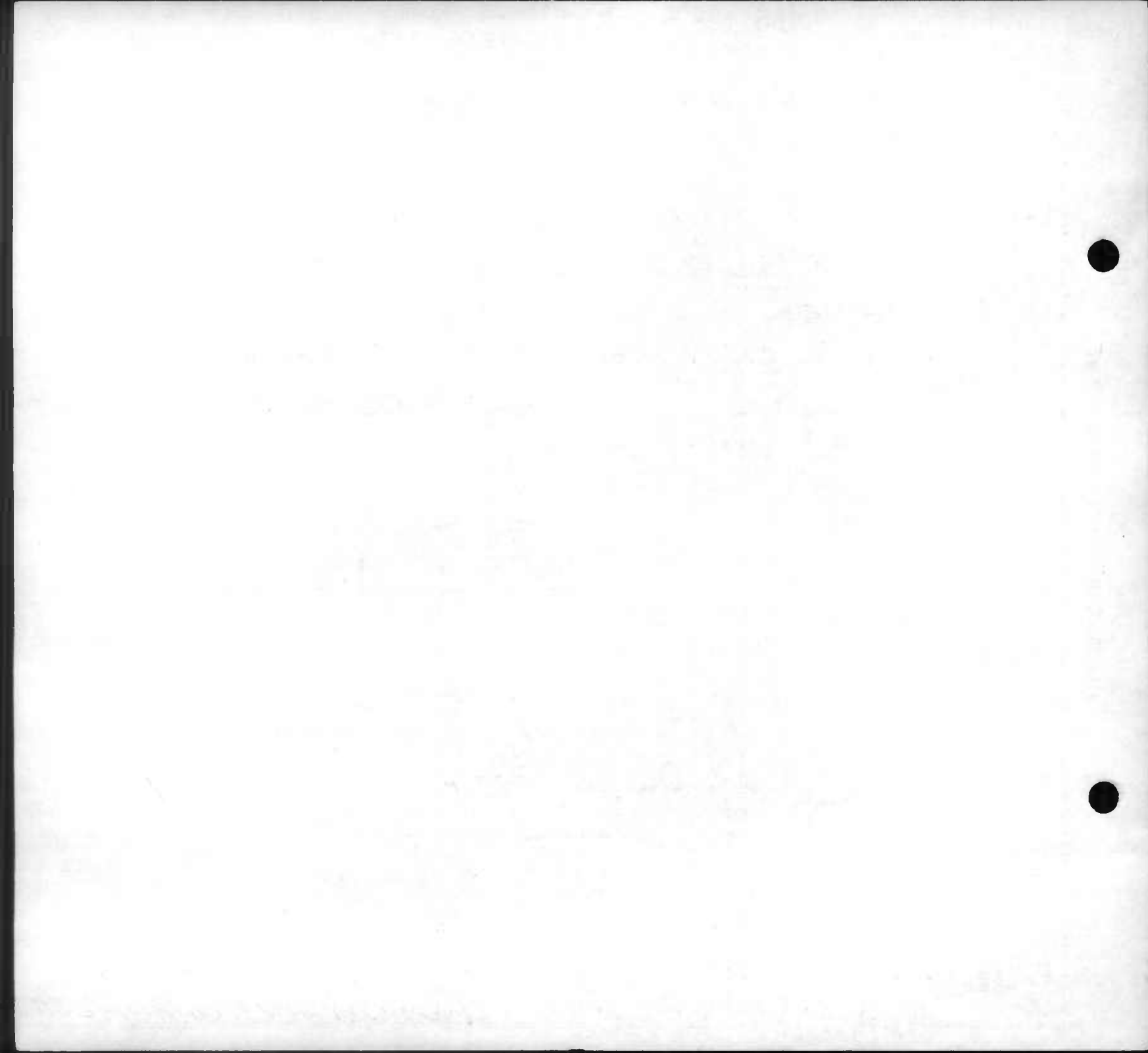
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JAN 10 1960

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|--|--|
| 65 12898 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 12898 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Lillian KACZMAREK | | DEC. 17, 1965 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE | | B. COUNTY | |
| ST. Joseph's Hospital | | Md. | | 6-02 | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | |
| F. | | White | | MARRIED | |
| 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| Oct. 24, 1898 | | 67 | | Housewife | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Maryland | | USA | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| Ignatius Cieslinski | | Agnes Smiegiewski | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | | | Joseph KACZMAREK 28 N. Lakewood Ave. | |
| 18. 4-22-11 | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) Intermittent CVD | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (B) Pulmonary Fibrosis | | | |
| ANTECEDENT CAUSES | | (C) | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Approx.) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1940 to 12-17-65, that (I) (we) last saw the deceased alive on 12-17-65 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Theodore T. Nizich, M.D. | | | | 12-20-65 | |
| 25C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| | | 429 S. Chester St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 12/22/65 | | St. Stanislaus Cem. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| DEC 20 1965 | | Robert E. Johnson | | B. Dabrowski 2818 E. Baltimore St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12899 | |
|---|---------------------|--|-----------------------------------|---|--|
| BIRTH NO. 65 12899 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Benjamin F. Jenkins | | 2. DATE AND HOUR OF DEATH
12-18-65 2⁰⁰ A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY 21-02 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
48 Maryland General Hospital
827 Linden Ave. 21201 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 30 | | | |
| | | D. STREET ADDRESS (If rural, give location)
1243 Carroll St | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
4-1-82 | 9. AGE (In years last birthday)
83 | If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Grocer | | 10B. KIND OF BUSINESS OR INDUSTRY
Self Employed | | 11. BIRTHPLACE (State or foreign country)
Baltimore Md? | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Jenkins Frederick | | 14. MOTHER'S MAIDEN NAME
Catherine Ryan | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-03-9781 | | 17. INFORMANT
Hospital Chart | |
| 18. 42011 I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) myocardial infarction | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Arteriosclerotic heart disease | | | |
| | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/12 1965 to 12/18 1965 , that (I) (we) last saw the deceased alive on 12/18 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
John M. Steffy | | | | 23B. DATE SIGNED
12/18/65 | |
| 23C. PHYSICIAN'S NAME (Type)
JOHN M. STEFFY | | | | 23D. ADDRESS
827 Linden Ave 21201 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12/21/65 | | 24C. NAME OF CEMETERY or CREMATORY
New Cathedral Cem. | |
| 24D. LOCATION (City, town, or county) (State)
4310 Old Frederick Rd. | | 24E. FUNERAL DIRECTOR
John J. Cowan & Son Inc. | | 24F. ADDRESS
3501 N. ... | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 25B. NAME OF REGISTRAR
Robert ... | | 25C. FUNERAL DIRECTOR
John J. Cowan & Son Inc. | |

33-10000-1
 CASE RELEASED AS NON-MEDICAL EXAMINER'S CASE 12 19 65
 HENRY M E OFFICE
 PER MR
 FUNERAL DIRECTOR: IMPORTANT
 6 26 65

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12900 | |
|---|---------|--|--------------------------------------|---|--|
| BIRTH NO. 65 12900 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | KOTHE, CHARLES(Charles Ferdinand Kothe) | | 12-19-65 8AM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | |
| THE JOHNS HOPKINS HOSPITAL | | | | MARYLAND | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| | | | | BALTIMORE | |
| | | | | D. STREET ADDRESS (If rural, give location) | |
| | | | | 2738 HARFORD ROAD | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min. |
| M | W | WIDOWER | 6-26-88 | 77 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Paper Hanger | | Retired | | Baltimore Maryland | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| WILLIAM KOTHE | | | MATILDA Unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| NO | | | | | |
| 17. INFORMANT | | | ADDRESS | | |
| Mr. Raymond H. Kothe | | | 1726 Abbotston Street 21218 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease or injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | A acute myocardial infarction 5 hrs. | | |
| ANTECEDENT CAUSES | | | ASCVD | | |
| DISEASES OR CONDITIONS, if any, gave rise to the above cause (A) stating UNDERLYING CONDITION last. | | | years | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3:00 AM 12-19 19 65 to 8:00 AM 12-19 19 65, that (I) (we) last saw the deceased alive on 12-19 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Nicholas J. Fortuin | | | | 12-19-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| NICHOLAS J. FORTUIN | | | | THE JOHNS HOPKINS HOSPITAL, BALTIMORE, MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 12/22/65 | | Lorraine | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| DEC 20 1965 | | R. E. S. Fortuin | | Henry Sander & Sons Inc. | |
| | | | | Baltimore Maryland 21213 | |



FUNERAL DIRECTOR: IMPORTANT

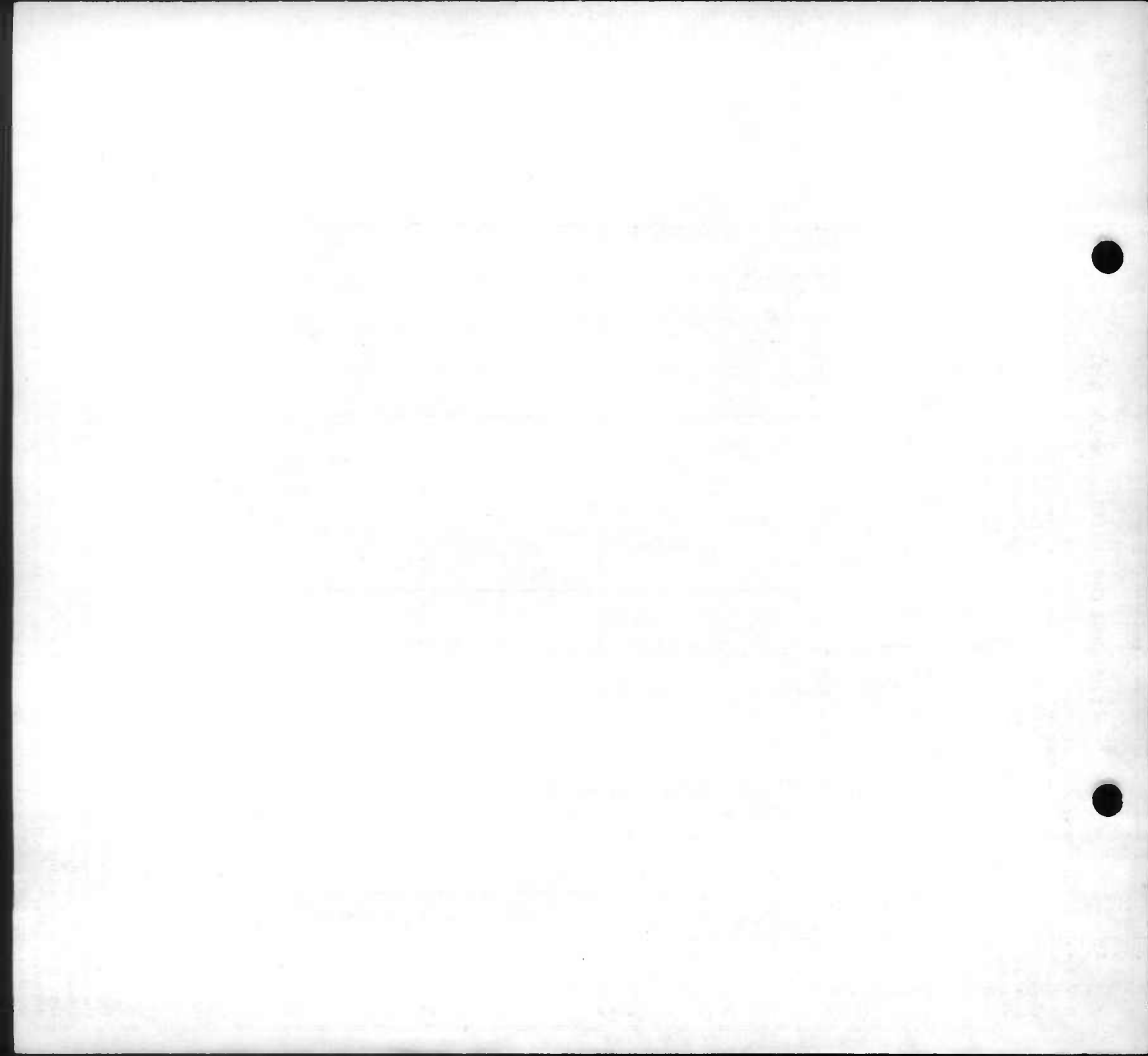
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|---|--|--|--|
| BIRTH NO. <u>65-31995 65 12901</u> | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. <u>65 12901</u> | |
| 1. NAME OF DECEASED
(Type or Print) <u>BABY GIRL BROOKS</u> | | | 2. DATE AND HOUR OF DEATH
<u>12-16-65</u> <u>12:30</u> P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>MERCY HOSP 2120V</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY <u>Harford</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>ABINGDON</u>
D. STREET ADDRESS (If rural, give location)
<u>Bx 419-B Emmorton Rd.</u> | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
<u>12-16-65</u> | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: Hours: Min. <u>30</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>-</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>-</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | |
| 13. FATHER'S NAME
<u>WILLIAM T. BROOKS</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA.</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
<u>WILLIAM T. BROOKS</u> |
| 18. <u>776X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH
(A) <u>IMMATURITY</u>
DUE TO
<u>LABOR + PREMATURE DELIVERY</u>
(B) <u>INCOMPETENT CERVIX</u>
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12-16-65</u> to <u>12-16</u> 19 <u>65</u> , that (I) (we) lost saw the deceased alive on <u>12-16</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Joseph P. Boggio</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED
<u>12-17-65</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Joseph P. BOGGIO</u> | | | 23D. ADDRESS
<u>715 N. CHARLES ST. 21201</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Hospital disposal</u> | | 24B. DATE
<u>DEC 20 1965</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>HOSPITAL DISPOSAL</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>DEC 20 1965</u> | | 25B. NAME OF REGISTRAR
<u>John E. Johnson</u> | | 25C. FUNERAL DIRECTOR
<u>HOSPITAL DISPOSAL</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|--|---|--|------------------------------------|--|
| 65 12902 | | CERTIFICATE OF DEATH | | 65 12902 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| BENJAMINE REED, BENJAMIN HARRISON | | | 12/15/65 11:35 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| 33 THE JOHNS HOPKINS HOSPITAL | | | MARYLAND BALTIMORE | | |
| 5. SEX | | | 6. RACE | | |
| MALE | | | WHITE | | |
| 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | | | 8. DATE OF BIRTH | | |
| MARRIED | | | 11-24-88 | | |
| 9. AGE (In years last birthday) | | | 10. CITIZEN OF WHAT COUNTRY? | | |
| 77 | | | USA | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | |
| Mine Electrician Consolidated Coal Co. | | | Kentucky | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| JOHN REED | | | Rachel Connolly | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| No | | | 404-01-4930 | | |
| 17. INFORMANT | | | ADDRESS | | |
| Estill Reed | | | 613 F. Street | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | 20 hours. | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 12/2/65 | | | Abdominal Aortic Aneurysm | | |
| 20A. AUTOPSY? (Yes or No) | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| No | | | No | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| No | | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED | | |
| | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/26/65 to 12/15/65, that (I) (we) last saw the deceased alive on 12/15/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | 23B. DATE SIGNED | | |
| Robert A. Ratcheson | | | 12/15/65 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| ROBERT A. RATCHESON | | | JOHNS HOPKINS HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 12-18-65 | | Gardens of Faith Cem. | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. LOCATION (City, town, or county) (State) | | | |
| Baltimore Md. | | Baltimore Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| DEC 20 1965 | | R. E. [Signature] | | R. E. [Signature] | |
| ADDRESS | | ADDRESS | | | |
| 1211 Chesaco Ave. | | 1211 Chesaco Ave. | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|--------------|---|----------------------------|---|--|--|--|---------|-------------------------------------|----------------------------------|
| BIRTH NO. 64-16298 65 12903 | | | | | CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | | | | Registered No. 65 12903 | | | | | |
| 1. NAME OF DECEASED
(Type or Print)
Martin Eric Charles | | | | | 2. DATE AND HOUR OF DEATH
12-16-65 3:30 pm M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
49 North Charles General | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY
403 Braxton Ct Harford
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Balto. (Joppa) Md 62-00
D. STREET ADDRESS (If rural, give location) | | | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
4-8-64 | 9. AGE (In years last birthday)
1 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Martin Charles Robert | | | | | 14. MOTHER'S MAIDEN NAME
Peters Kathleen | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Mr. Charles R. Martin | | ADDRESS
(Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Pneumonia Meningitis
DUE TO
Gastric Borechnumonia
DUE TO
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | CAUSE OF DEATH
Pneumonia Meningitis
Gastric Borechnumonia
DUE TO
DUE TO
DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/15/65 19 65 to 12/16/65 19 65, that (I) (we) last saw the deceased alive on 12/16/65 at 5:30 pm 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE
Clarence M. Sullivan | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
12/16/65 | | | |
| 23C. PHYSICIAN'S NAME (Type)
GEORGE J. DENDRINOS | | | | | 23D. ADDRESS
424 Harford med Ctr bldg. - Joppa Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12/20/65 | | 24C. NAME OF CEMETERY or CREMATORY
Gardens of Faith Cemetery | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | |
| 25A. DATE OF DEATH
DEC 20 1965 | | 25B. NAME OF REGISTRAR
Clarence M. Sullivan | | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck Inc. Balto. Md. 21214 | | | ADDRESS | | |

12/29/65 - Cause of Death - H. Influenzae Meningitis - Type B
Information received from Dr. George H. Pendino (att. Phys.)
by phone

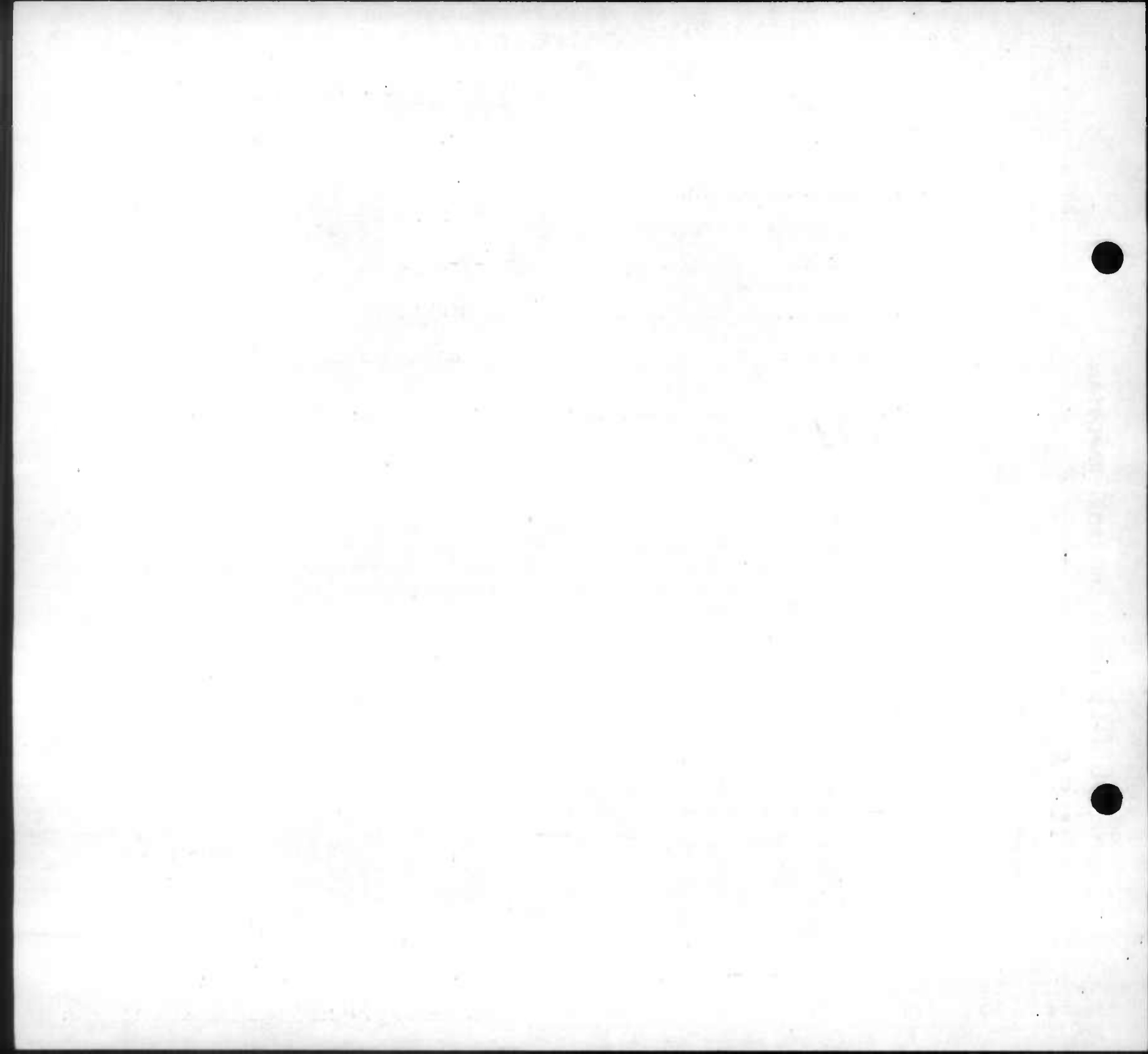
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|---|--|---|
| BIRTH NO.
65 12904 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 65 12904 | |
| 1. NAME OF DECEASED
(Type or Print)
<i>Charles B. Koch</i> | | | 2. DATE AND HOUR OF DEATH
<i>Dec. 16, 1965 7:30 A M.</i> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
<i>1015 Cedarcroft Road</i> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Md.</i>
B. COUNTY <i>27-48</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i>
D. STREET ADDRESS (If rural, give location)
<i>1015 Cedarcroft Road</i> | | |
| 5. SEX
<i>male</i> | 6. RACE
<i>white</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>married</i> | 8. DATE OF BIRTH
<i>8-5-1898</i> | 9. AGE (In years last birthday)
<i>67</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Ret. Salesman</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Ohio</i> |
| 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | 13. FATHER'S NAME
<i>William Koch</i> | | |
| 14. MOTHER'S MAIDEN NAME
<i>Mable Brande</i> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO.
<i>705050188</i> | | | 17. INFORMANT
<i>Mrs Agnes E. Koch</i> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>420.1 I Myocardial Infarct</i> | | | INTERVAL BETWEEN ONSET AND DEATH
<i>Sudden</i> | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<i>Bronchitis, chronic</i> | | | 6 months | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1956 to 16 Dec 1965</i> , that (I) (was) lost saw the deceased alive on <i>18 Nov 1965</i> and that in (my) (was) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Charles E. Shaw M.D.</i> | | | | 23B. DATE SIGNED
<i>16 Dec 65</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Charles E. Shaw, M.D.</i> | | | | 23D. ADDRESS
<i>607 W. Joppa Road Baltimore, Md 21204</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>burial</i> | | 24B. DATE
<i>12-20-65</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>St. Stanislaus Cem.</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>DEC 20 1965</i> | | | |
| 25B. NAME OF REGISTRAR
<i>Leonard J. Ruck</i> | | 25C. FUNERAL DIRECTOR
<i>Leonard J. Ruck Inc Baltimore, Md.</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|--|---|---|
| 65 12905 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 12905 | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | |
| | | | | Robert L. Ray | |
| 2. DATE AND HOUR OF DEATH | | Dec. 17, 1965 1:20 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | A. STATE
Md. | | | |
| Union Memorial Hospital | | B. COUNTY
27-05 | | | |
| C. CITY OR TOWN
(If outside city limits, write RURAL and give township) | | D. STREET ADDRESS
(If rural, give location) | | | |
| Baltimore | | 3102 Chesley Ave. | | | |
| 5. SEX
male | 6. RACE
white | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
June 11, 1903 | 9. AGE (In years
last birthday)
62 | 10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)
Ret. Carpenter |
| 11. BIRTHPLACE (State or foreign country)
North Carolina | | | 12. CITIZEN OF
WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
Robert L. Ray | | 14. MOTHER'S MAIDEN NAME
C. Eva Penney | | 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
no | |
| 16. SOCIAL SECURITY NO.
237145097 | | 17. INFORMANT
Sola S. Ray | | ADDRESS
same | |
| 18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, osthenia, etc. It means the disease,
injury or complication which caused death.)
420.1 + 260X | | CAUSE OF DEATH
(A) DUE TO
Coronary Thrombosis | | INTERVAL BETWEEN
ONSET AND DEATH
Instant | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last,
II | | (B) DUE TO
Coronary Heart Disease | | 2 mos | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT. | | (C) Gen. Arteriosclerosis | | ? | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.) | | 21C. WHERE DID
INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME
OF INJURY
(APPROX.) | | 21E. INJURY OCCURRED
While At <input type="checkbox"/> Not While
Work At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-4-1950 to 12-17-1965.
that (I) (we) last saw the deceased alive on 12-17-1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Deceased 1:20 A.M. | | | | | |
| 23A. SIGNATURE
Robert L. Ray | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
12-17-65 | |
| 23C. PHYSICIAN'S
NAME (Type)
R. H. Siver | | 23D. ADDRESS
M.D. 3105 N. Charles St. Balto. 21218 | | | |
| 24A. BURIAL CREMATION,
REMOVAL (Specify)
burial | | 24B. DATE
12-20-65 | | 24C. NAME OF CEMETERY or CREMATORY
Dulaney Valley Mem. | |
| 24D. LOCATION
(City, town, or county)
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | | |
| 25B. NAME OF REGISTRAR
Robert L. Ray | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck Inc | | ADDRESS
Baltimore, Md. | |

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18-17-52 1-17-52 18-17-52

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18-17-52

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|--|---|--|---|--|
| BIRTH NO.
65 12906 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 65 12906 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) FOGLIA, ETHEL C. | | 2. DATE AND HOUR OF DEATH
12/17/65 4:20 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore #34 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
UNION MEMORIAL HOSP. | | D. STREET ADDRESS (If rural, give location)
7801 OAKLEIGH RD. 21234 | | 5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
— | | 8. DATE OF BIRTH 10/8/08 9. AGE (In years last birthday) 57 | |
| 13. FATHER'S NAME
? | | 14. MOTHER'S MAIDEN NAME
? | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
UNK No | | 16. SOCIAL SECURITY NO.
— | | 17. INFORMANT
FRANK FOGIA | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
491X I | | CAUSE OF DEATH
Bronchopneumonia | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO
Chronic respiratory failure | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (B) DUE TO
Plural & pulmonary fibrosis | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that 11 (this hospital) attended the deceased from 11/27 19 65 to 12/17 19 65 , that 1 (we) last saw the deceased alive on 12/17 19 65 and that in 11 (our) opinion death occurred on the date and hour and from the causes stated above. 11 (We) (did) (did not) view the body after death. | | 23A. SIGNATURE
Robt Whitlock | | 23B. DATE SIGNED
12/17 | |
| 23C. PHYSICIAN'S NAME (Type)
ROBERT WHITLOCK | | 23D. ADDRESS
UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12/20/65 | | 24C. NAME OF CEMETERY or CREMATORY
Dulaney Valley Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 25B. NAME OF REGISTRAR
Robert J. F... | |
| 25C. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. | | 25D. ADDRESS
817 N. 14th St. Baltimore, Md. | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 65 12907 | |
|--|-----------|--|--|--|---------------------------------------|--|--|
| BIRTH NO. 65 12907 | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) MR. (JAN) JOSEPH BISHOP | | 2. DATE AND HOUR OF DEATH
12/18/65 2 A M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Balto | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Union Memorial Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 33-00 | | | | | |
| | | D. STREET ADDRESS (If rural, give location)
1003 Steward Ave. | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
married | | 8. DATE OF BIRTH
12/31/02 | 9. AGE (In years last birthday)
62 | 10. If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
ACCOUNTANT | | 10B. KIND OF BUSINESS OR INDUSTRY
RAILROAD | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
GEORGE BISHOP | | | | 14. MOTHER'S MAIDEN NAME
SUSAN HAGERTY | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
UNK | | 16. SOCIAL SECURITY NO.
UNCC | | 17. INFORMANT
BEATRICE BISHOP | | ADDRESS
S/A | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
163X I
Brain Metastases | | | | CAUSE OF DEATH
(A) DUE TO
Carcinoma of lung | | INTERVAL BETWEEN ONSET AND DEATH
unknown
one year | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | |
| (C) | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (H) (this hospital) attended the deceased from 11/24/65 to 12/18/65, that (H) (we) last saw the deceased alive on 12/18/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Robert N. Whitlock | | | | M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
12/18/65 | |
| 23C. PHYSICIAN'S NAME
ROBERT N. WHITLOCK | | | | 23D. ADDRESS
UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12/21/65 | | 24C. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 25B. NAME OF REGISTRAR
Leonard J. Ruck | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck Inc | | ADDRESS
5305 Harford Rd. | |

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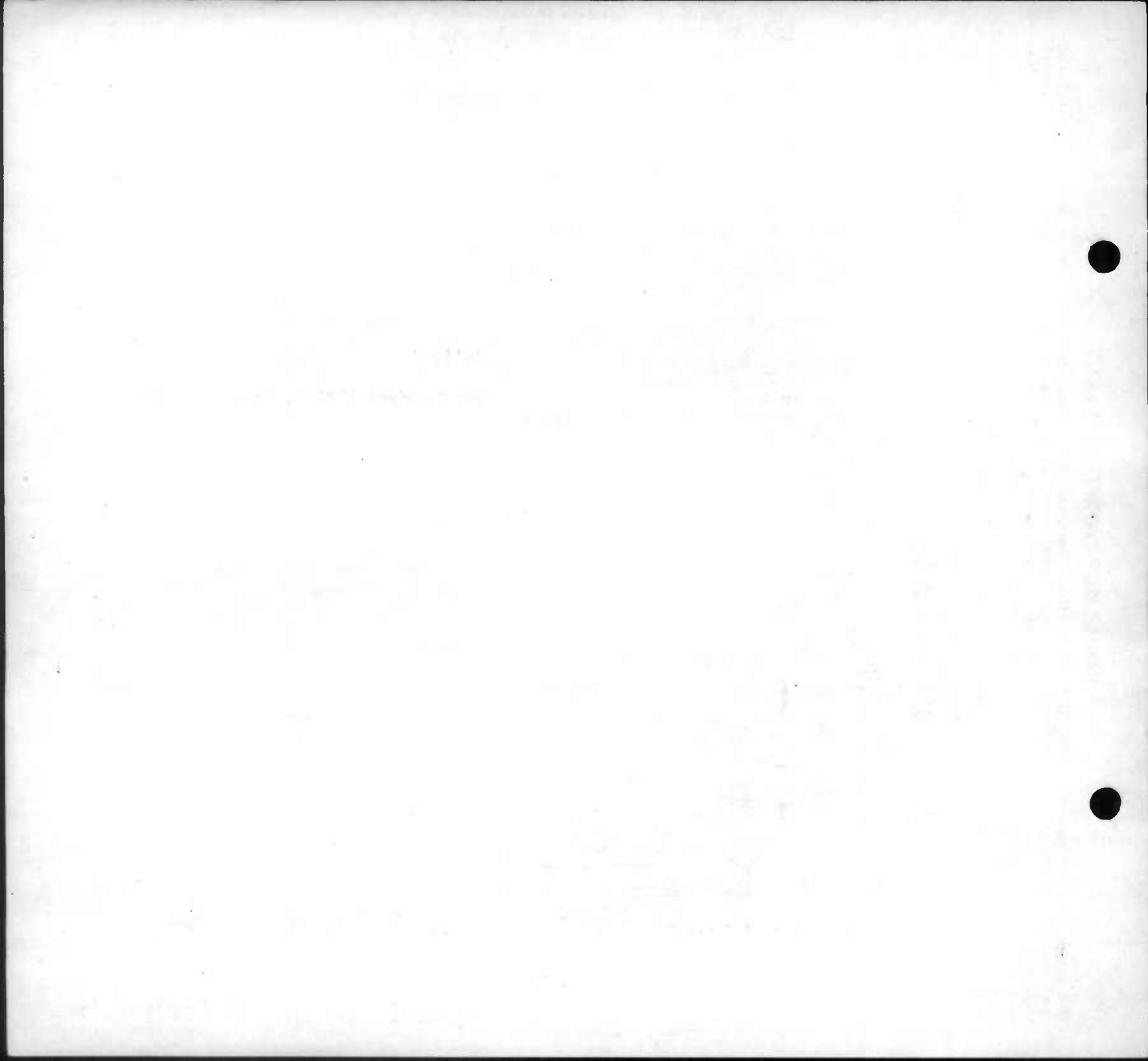
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12908 | |
|---|---------|--|---|--|-----------------------------|
| 65 12908 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| JOHN LEONARD | | | 12-16-65 12.30 A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| THE JOHNS HOPKINS HOSPITAL | | | MARYLAND | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| | | | BALTIMORE | | |
| | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | 1724 NORTH CAROLINE STREET | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| MALE | NEGRO | MARRIED | 9-7-87 | 78 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | N. Carolina | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| JAMES LEONARD | | | Julia ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| yes W. War I | | | | Van Leonard 1724 N. Caroline Street | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| 466X I | | | (A) Acute repeated pulmonary emboli | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) Prob deep venous thrombosis | | |
| II | | | (C) | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/14/65 to 12/15/65, that (I) (we) last saw the deceased alive on 12/15/65 and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| R. I. Keimowitz M.D. | | | | 12/16 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| R. I. Keimowitz M.D. | | | | Johns Hopkins Hosp | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 12-21-65 | | Baltimore National | |
| | | | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| DEC 20 1965 | | Marshall Jones, Jr. | | 1735 Harford Av. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

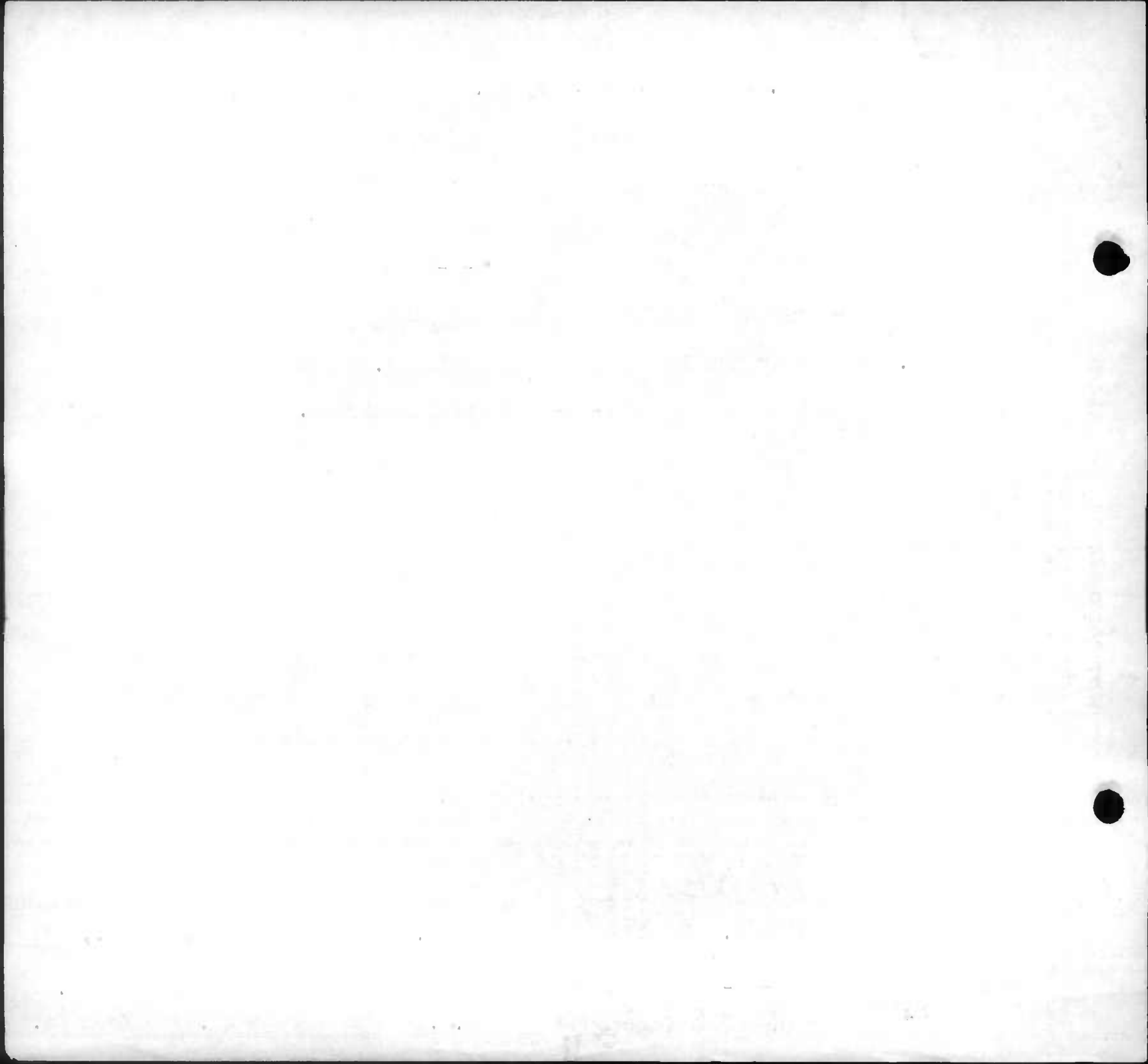
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|---------------------|--|--------------------------------------|--|--|
| BIRTH NO. 65 12909 | | | | 65 12909 | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) ALLEN; MAY MAE | | | | 12-17-65 9:00 a.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
BONSECOURS Hosp. BALTO. MD | | | | A. STATE
MD
B. COUNTY
1709 N. Lombard St | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE MD | |
| | | | | D. STREET ADDRESS (If rural, give location)
19-04 | |
| 5. SEX
Fe | 6. RACE
N | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
3/27/1900 | 9. AGE (In years last birthday)
65 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
KNITTER | | 10B. KIND OF BUSINESS OR INDUSTRY
HARRY | | 11. BIRTHPLACE (State or foreign country)
Tennessee | |
| 13. FATHER'S NAME
William Webb | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service)
No No | | | | 16. SOCIAL SECURITY NO.
225-01-4713B | |
| 17. INFORMANT
John A Allen - 1709 W Lombard St | | | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
237X I
Brain Tumor | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-17-1965 to 12-17-1965 , that (I) (we) last saw the deceased alive on 12-17-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
J. Accinelli | | | | 23B. DATE SIGNED
12-17-65 | |
| 23C. PHYSICIAN'S NAME (Type)
JAIME ACCINELLI | | | | 23D. ADDRESS
Bon Secours Hosp. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
12/20/65 | | 24C. NAME OF CEMETERY or CREMATORY
BALTO. NAT'L Cem | |
| | | | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE MD | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 25B. NAME OF REGISTRAR
John A. Allen | | 25C. FUNERAL DIRECTOR
Thomas J. Kenny Inc - 1600 Hollins St | |

Baker

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 12910 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 12910 | |
|--|--------------|---|--|--|---|--|-------------------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Dr. John Mason Hundley Jr. | | | | 2. DATE AND HOUR OF DEATH
December 18, 1965 12:05 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
204 Ridgewood Road | | | | A. STATE
Maryland | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
204 Ridgewood Road | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
7-8-1891 | 9. AGE (In years last birthday)
74 | If Under 1 Yr.
Months Days | | If Under 24 Hrs.
Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Physician-Surgeon | | | 10B. KIND OF BUSINESS OR INDUSTRY
Medical | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Dr. John Mason Hundley | | | | 14. MOTHER'S MAIDEN NAME
Helen M. Sweet | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WW 1 | | | | 16. SOCIAL SECURITY NO.
213-46-4283 | | 17. INFORMANT
Emily Louise H. Hundley | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) Coronary thrombosis
DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
6 hr. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from MAY 13 1958 to DEC 18 1965, that (I) (we) last saw the deceased alive on DEC 18 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Joseph B. King | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
12-20-65 | |
| 23C. PHYSICIAN'S NAME (Type)
Joseph B. King | | | | 23D. ADDRESS
222 W. Cold Spring Lane, Balto., Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12-20-65 | | 24C. NAME OF CEMETERY or CREMATORY
London Park | | 24D. LOCATION (City, town, or county) (State)
Baltimore Md. | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
DEC 20 1965 | | 25B. NAME OF REGISTRAR
H. W. Jenkins | | 25C. FUNERAL DIRECTOR
H. W. Jenkins & Sons Co. 4905 York Rd. | | | |



45-47-64

JJ
SAB

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|---|----------------------|---|--|---|--|--|--|----------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 12911 | | | | | |
| BIRTH NO. 65 12911 | | | | | 2. DATE AND HOUR OF DEATH 12-18-65 8:20 P.M. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Long, Carrie</u> | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Baltimore City Hospitals BCH</u> | | | | | A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>(RURAL)</u> <u>53-00</u> | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <u>924 WOODLYN ROAD 21221</u> | | | | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>WIDOWED</u> | 8. DATE OF BIRTH <u>6-27-94</u> | 9. AGE (In years last birthday) <u>71</u> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME <u>HENRY WITTIG</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>BERTHA HOYT</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT ADDRESS <u>RECORDS: BCH 4940 EASTERN AVENUE #21224</u> | | | | | |
| 18. CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | (A) <u>Carcinomatosis brain</u> | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | (B) <u>Metastatic CA breast</u> | | | | | |
| ANTECEDENT CAUSES | | | | | (C) <u>1 1/2 years</u> | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | | White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>12-18-65</u> 19 to <u>12-18-65</u> 19, that (1) (we) last saw the deceased alive on <u>8:00 pm 12-18-65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) did (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE <u>Brian O. Bouton, MD</u> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <u>12-18-65</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>BRIAN BOUTON</u> | | | | | 23D. ADDRESS <u>4940 Eastern Avenue, Baltimore, Maryland</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>12-22-65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>OAK LAWN Cem.</u> | | | 24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 20 1965</u> | | | 25B. NAME OF REGISTRAR <u>John E. Miller</u> | | | 25C. FUNERAL DIRECTOR ADDRESS <u>2334 Jefferson St</u> | | | | |

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Person born
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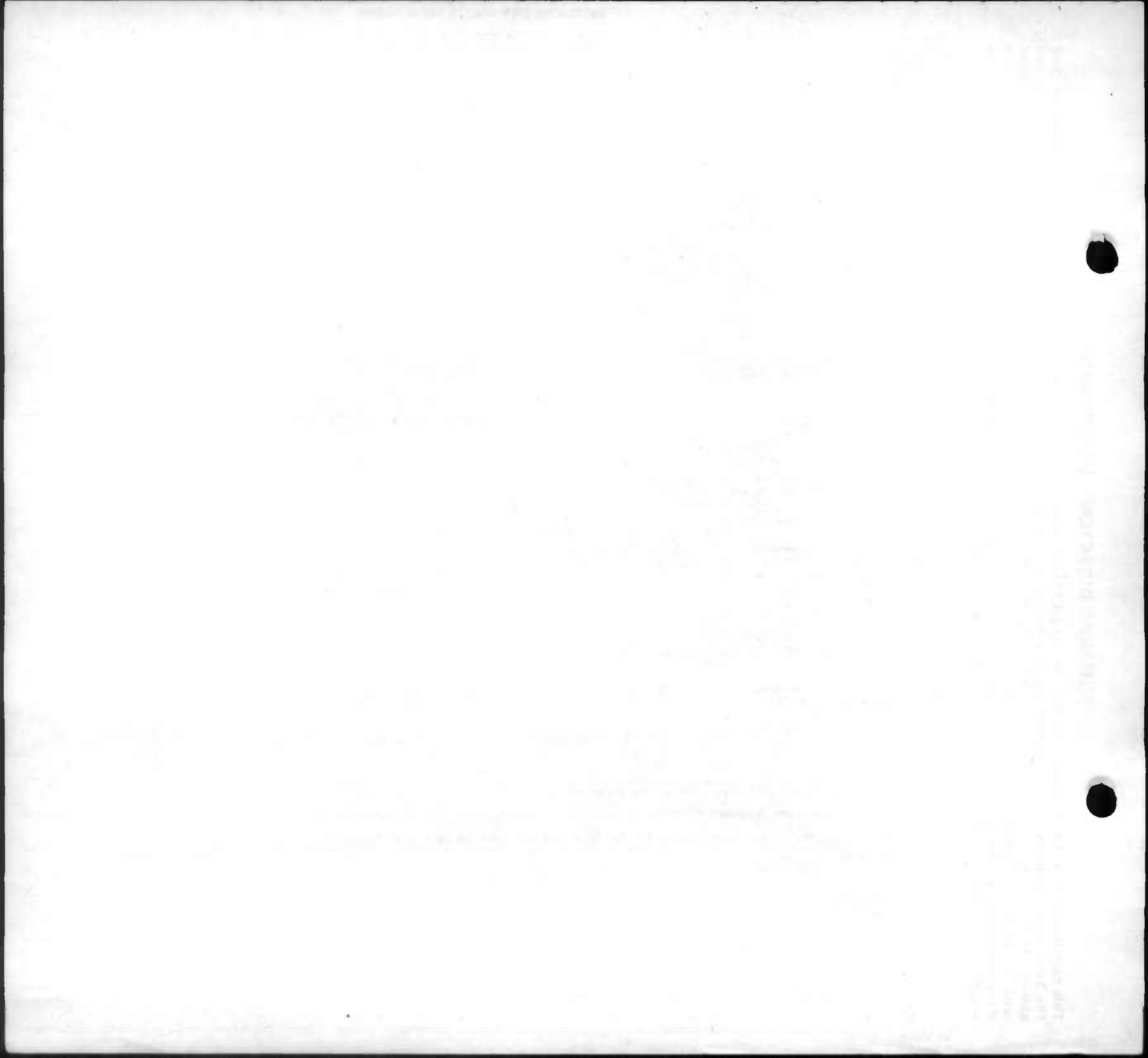
HCH

15-11-51

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

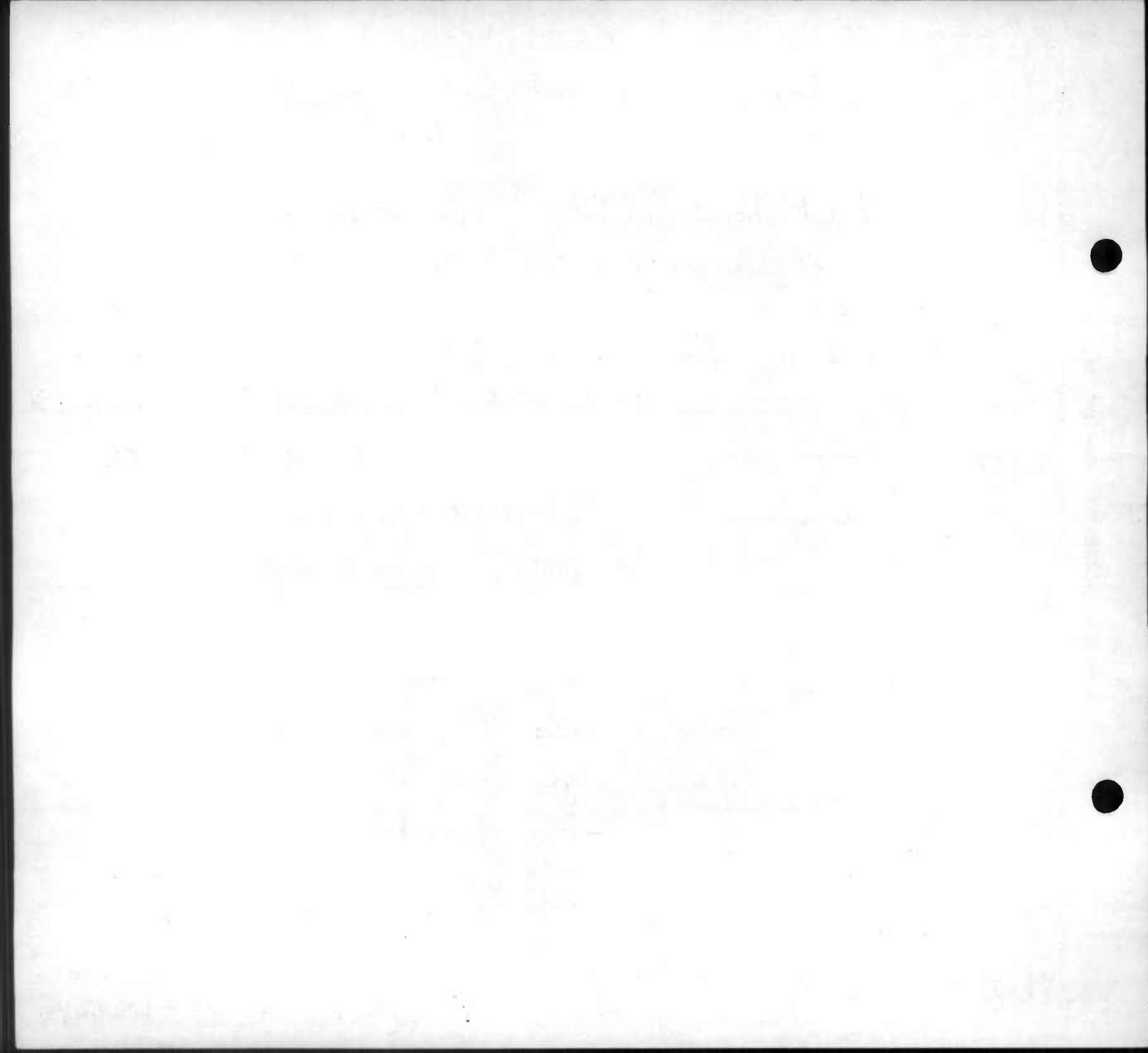
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|---|--|---------------------|--|--|--|--|--|---|--|--|--|
| BIRTH NO. | | 65 12912 | | | | CERTIFICATE OF DEATH | | | | Registered No. 65 12912 | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) FREDERICK W. HOHMAN | | | | | | 2. DATE AND HOUR OF DEATH
12-15-65 | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY 603 | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
2319 JEFFERSON ST. | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location)
2319 JEFFERSON ST. | | | | | |
| 5. SEX
M | | 6. RACE
W | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | | 8. DATE OF BIRTH
5-23-1896 | | 9. AGE (In years last birthday)
69 | | 10. If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MECHANIC | | | | 10B. KIND OF BUSINESS OR INDUSTRY
TRANSIT Co. | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
FREDERICK W. HOHMAN, JR. | | | | | | 14. MOTHER'S MAIDEN NAME
LENA BAUERNSCHMIDT | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
213-10-0048 | | 17. INFORMANT ADDRESS
Mrs. Helen Hohman - 2319 Jefferson St. | | | | | |
| 18. 334X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CONGESTIVE HEART FAILURE | | | | | | CAUSE OF DEATH
(A) DUE TO
Cerebral Atherosclerosis
(B) DUE TO
Pulmonary Edema
(C) DUE TO | | | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH
310.
5 yr. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not-White At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb - 58 - 1959 to Dec - 15 - 1965 , that (I) (we) last saw the deceased alive on Dec - 15 - 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
W. G. Geyer | | | | | | 23B. DATE SIGNED
Dec-17-65 | | | | 23C. PHYSICIAN'S NAME (Type)
WILLIAM G. GEYER | |
| 23D. ADDRESS
156 N. Victoria Ave. | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | | | 24B. DATE
12-18-65 | | 24C. NAME OF CEMETERY or CREMATORY
BALTIMORE CEMETERY | | | | 24D. LOCATION (City, town, or county) (State)
BALTO., MD. | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | | | 25B. NAME OF REGISTRAR
Robert E. Johnson | | | | 25C. FUNERAL DIRECTOR ADDRESS
Starkey Miller - 2334 Jefferson St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | Registered No. 65 12913 | |
|--|----------------------|--|---|--|---|
| BIRTH NO. 65 12913 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Mary (or) Marie Biebel | | 2. DATE AND HOUR OF DEATH
Dec. 19-65 3:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 2-02 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
1819 E. Lombard St. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Balto. | | | |
| | | D. STREET ADDRESS (If rural, give location)
1819 E. Lombard St. | | | |
| 5. SEX
F. | 6. RACE
W. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
Sept 15 1890 | 9. AGE (In years last birthday)
75 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
At Home | | 10B. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Germany | |
| 13. FATHER'S NAME
Christian Bannasch | | 14. MOTHER'S MAIDEN NAME
Augusta Radtke | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213-54-0217 | | 17. INFORMANT
Evelyn A. Biebel 1819 E. Lombard St | |
| 18. 331X I | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) Cerebral hemorrhage due to | | | |
| ANTECEDENT CAUSES | | (B) cerebral arteriosclerosis | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) _____ | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/24/58 19 to 12/19 19 65 , that (I) (we) last saw the deceased alive on 2/17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (and) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Sam B. Kaplan | | | | 23B. DATE SIGNED
12/20/65 | |
| 23C. PHYSICIAN'S NAME (Type)
Irwin B. Kaplan | | 23D. ADDRESS
129 S. Broadway Balto 3, Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Dec 20 1965 | | 24C. NAME OF CEMETERY or CREMATORY
Oak Lawn Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Balto. Md | | 24E. FUNERAL DIRECTOR
Eastern Ave. Rd. Balto. Co | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 25B. NAME OF REGISTRAR
Blaise Stalder | | 25C. ADDRESS
1800 E. Lombard St | |

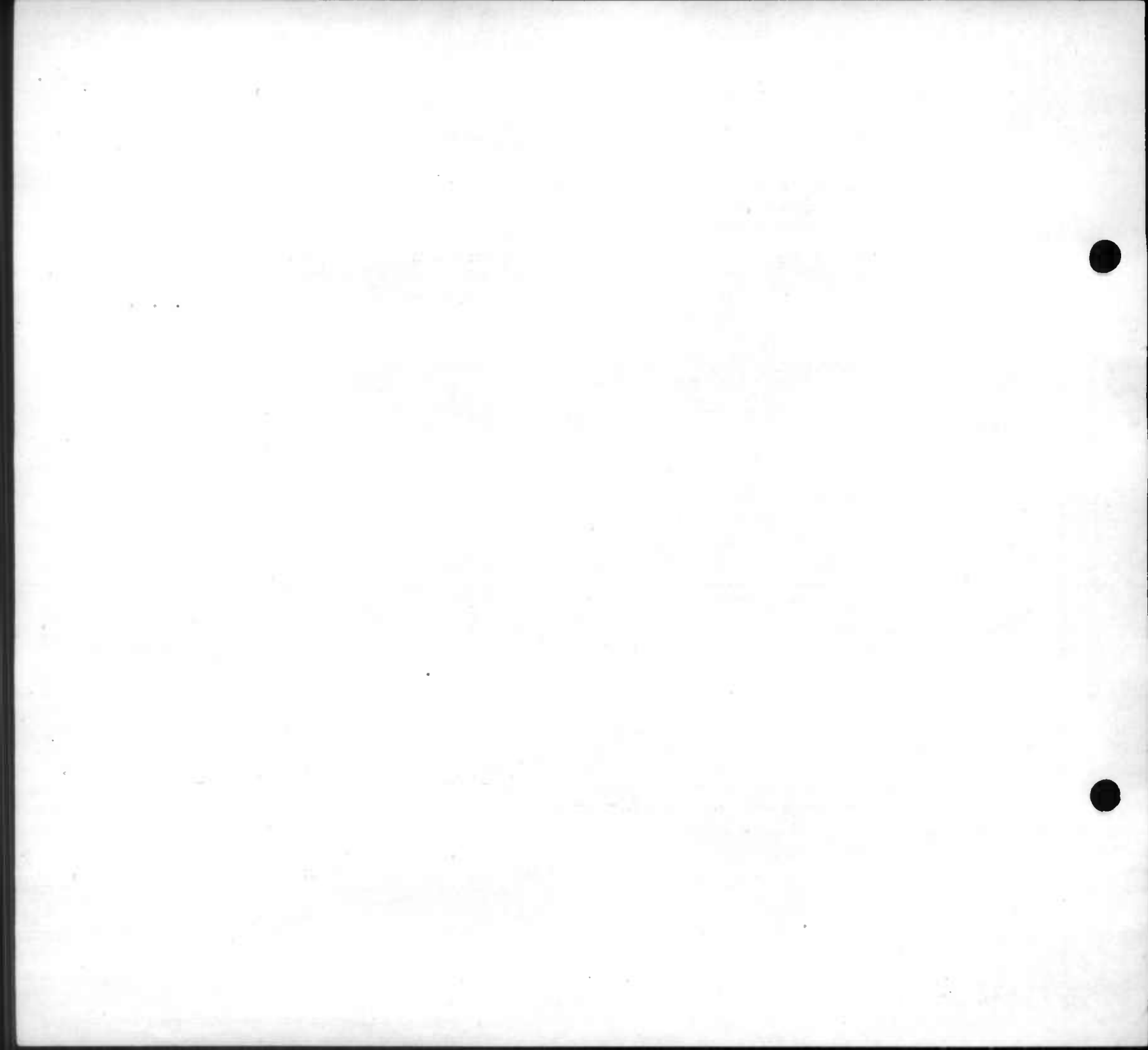


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 12914 | | CERTIFICATE OF DEATH | | Registered No. 65 12914 | |
|--|-------------------------|---|------------------------------------|--|--|--|--|-------------------------|--|
| 1. NAME OF DECEASED
(Type or Print) Reba Bailey | | | | 2. DATE AND HOUR OF DEATH
December 14, 1965 4:00^a M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Provident Hospital
1514 Division Street
Baltimore, Maryland | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 15-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 603 Collett Street | | | | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Unknown | 8. DATE OF BIRTH
Unknown | | 9. AGE (In years last birthday)
64 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Delaware | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| 18. 42.0.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Coronary Heart disease
DUE TO
(A) Coronary Heart disease
(B)
DUE TO
(C)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Fracture right femur | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No. | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-13-65 19 to 12-14-65 19, that (I) (we) last saw the deceased alive on 12-14-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Hosue C. Laredo | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
December 15, 1965 | | | |
| 23C. PHYSICIAN'S NAME (Type)
Hosue C. Laredo | | | | 23D. ADDRESS
1514 Division Street | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
DEC 16 1965 | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY
UNIVERSITY MEDICAL SCHOOL | | 24D. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 25B. NAME OF REGISTRAR
Charles E. Smith, M.D. | | 25C. FUNERAL DIRECTOR
MORTUARY SERVICE - BCDH | | | | | |

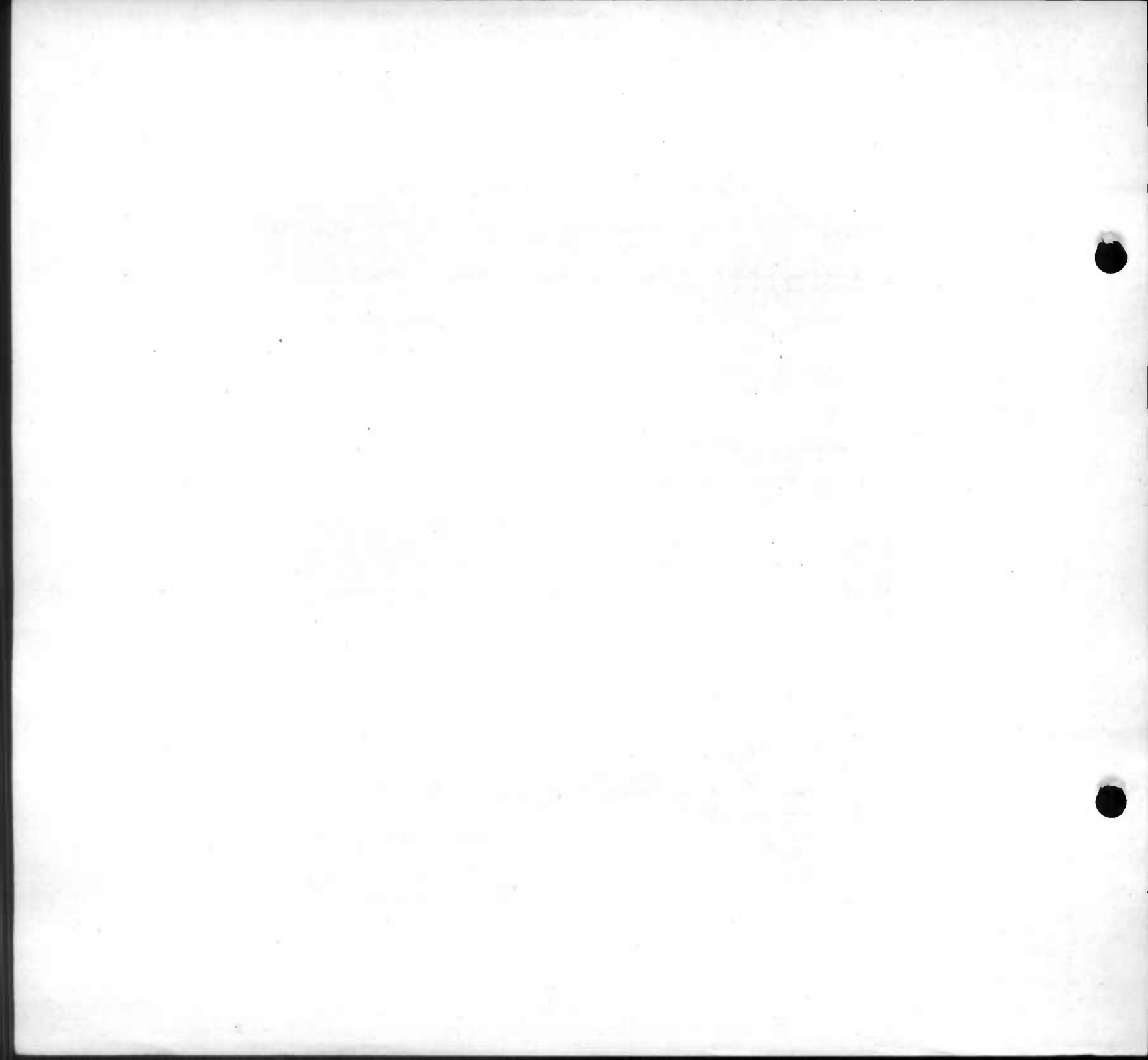


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 12915</u> | |
|--|------------------|---|---|--|---|
| BIRTH NO. <u>65 29613</u>
<u>65 12915</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print)
<u>BABY BOY SEWELL</u> | | 2. DATE AND HOUR OF DEATH
<u>11-27-65</u> <u>6:55 P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>LUTHERAN HOSPITAL of MARYLAND</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>BALTIMORE</u> B. COUNTY <u>MARYLAND</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>53-00</u>
D. STREET ADDRESS (If rural, give location) <u>205 Fifth Ave.</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>newborn</u> | 8. DATE OF BIRTH
<u>11-27-65</u> | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>BALTIMORE, MD</u> | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME
<u>Joseph W. Sewell</u> | | | 14. MOTHER'S MAIDEN NAME
<u>ELIZABETH Sewell Williams</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>750X I</u>
<u>Anencephaly</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | (B) DUE TO | |
| (C) DUE TO | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11-27-65 6:37pm</u> to <u>11-27-65 6:55pm</u> 19 <u>65</u> and that (I) (we) lost saw the deceased alive on <u>11-27-65</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Marcia Evangelista</u> | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
<u>MARCIA EVANGELISTA</u> | | 23D. ADDRESS
<u>LUTHERAN HOSPITAL of MARYLAND</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>DEC 16 1965</u> | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY
<u>UNIVERSITY MEDICAL SCHOOL</u> | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT.
<u>DEC 20 1965</u> | | | |
| 25B. NAME OF REGISTRAR
<u>John E. Seidman</u> | | 25C. FUNERAL DIRECTOR
<u>MORTUARY SERVICE - BOB</u> | | | |

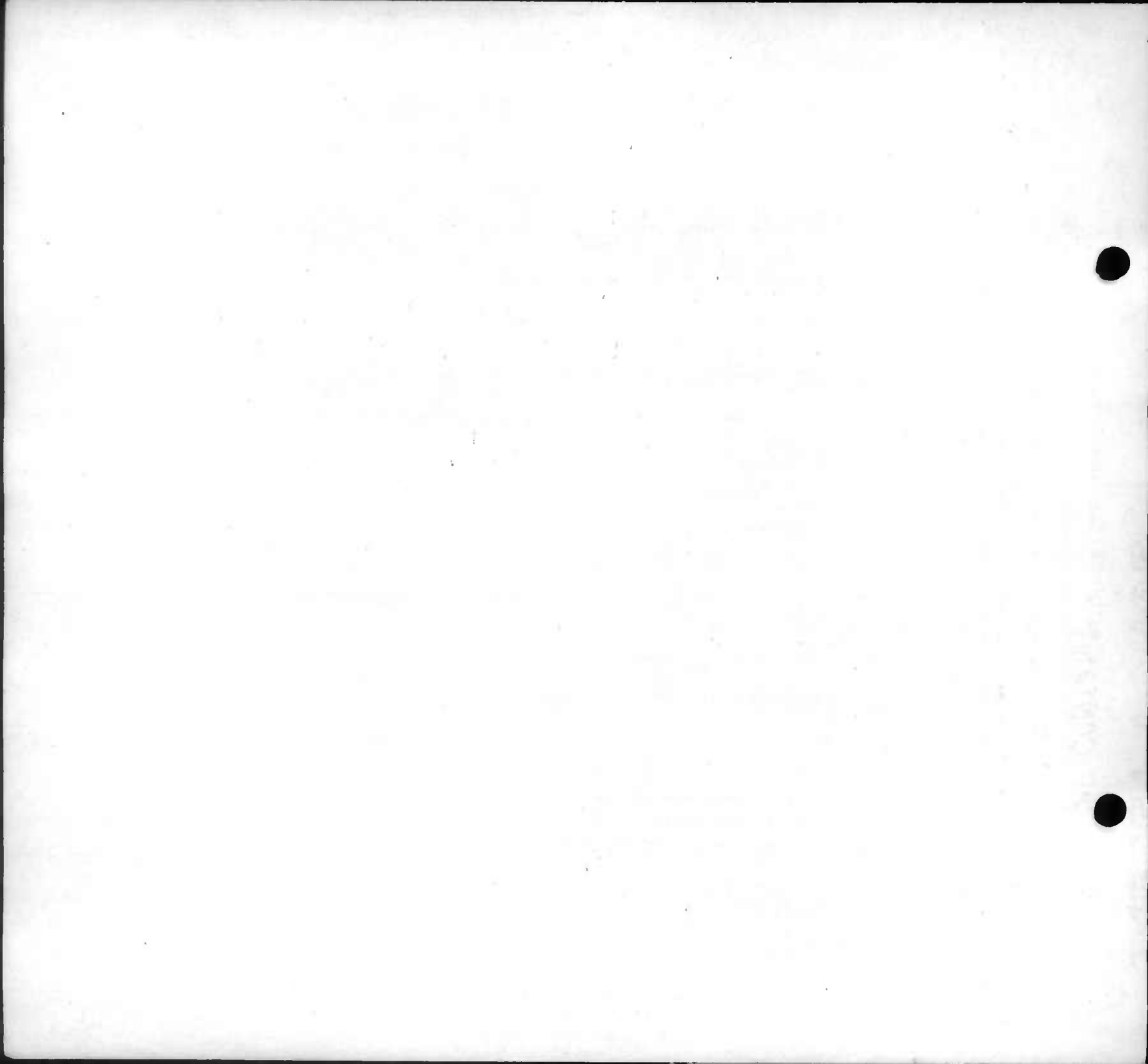


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|---------------------|---|-------------------------------------|--|--|---|--|
| BIRTH NO. 65 12916 | | CITY OF BALTIMORE | | DEPARTMENT OF HEALTH | | REGISTERED NO. 65 12916 | |
| 1. NAME OF DECEASED
(Type or Print) BABY BOY BILINSKI | | | | 2. DATE AND HOUR OF DEATH
11-27-65 2:15 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
LUTHERAN HOSPITAL OF MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY HANOVER
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
6300
D. STREET ADDRESS (If rural, give location)
HANOVER RD BOX 141B | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
NEWBORN | 8. DATE OF BIRTH
11-27-65 | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min.
2 hr | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Aleksander Belinski | | | | 14. MOTHER'S MAIDEN NAME
HELEN BILINSKI Polone | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| 18. 762.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
central anoxia = multiple skeletal deformities | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO
(B) DUE TO
(C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-27-65 12:20 PM 19 65 to 11-27-65 2:15 PM 19 65 , that (I) (we) last saw the deceased alive on 11-27-65 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Marcia Evangelista M.D. | | | | 23B. DATE SIGNED
11-27-65 | | 23C. PHYSICIAN'S NAME (Type)
MARCIA EVANGELISTA M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
DEC 16 1965 | | 24B. DATE
DEC 16 1965 | | 24C. NAME OF CEMETERY OR CREMATORY
UNIVERSITY MEDICAL SCHOOL | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MD. | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 25B. NAME OF REGISTRAR
Q. L. S. S. S. | | 25C. FUNERAL DIRECTOR
MORTUARY SERVICE - BCHD | | ADDRESS | |

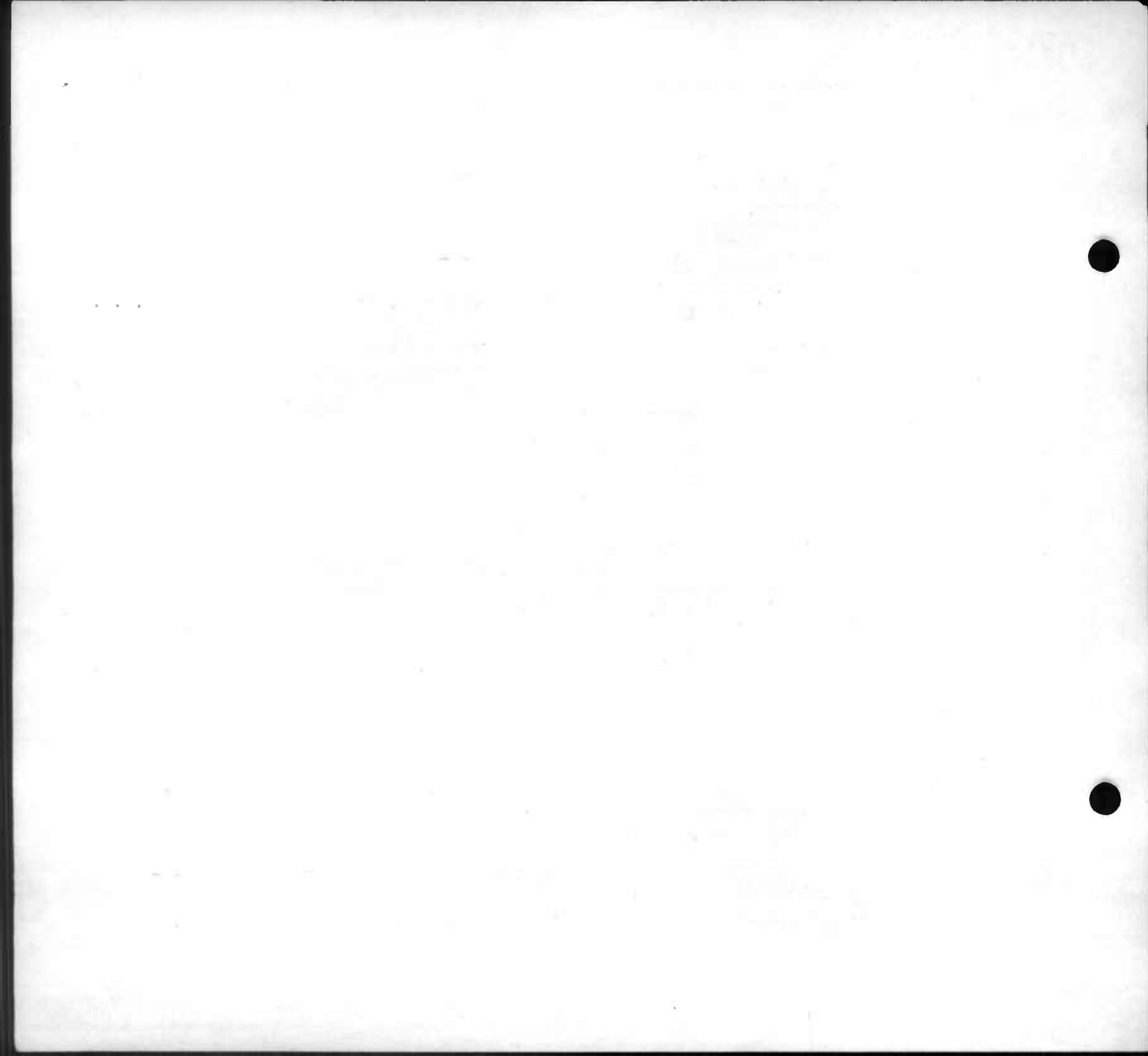


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 12917</u> | |
|--|-------------------------|---|------------------------------------|--|---|
| BIRTH NO. <u>65 12917</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. <u>65 12917</u> | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Baby of Roslyn Johnson</u> | | 2. DATE AND HOUR OF DEATH
<u>December 9, 1965</u> <u>1:00 A.</u> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>Provident Hospital</u>
<u>1514 Division Street</u>
<u>Baltimore, Maryland 21217</u> | | A. STATE
<u>Maryland</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u>
D. STREET ADDRESS (If rural, give location)
<u>2224 Ashburton Avenue</u> | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>Negro</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Single</u> | 8. DATE OF BIRTH
<u>12-9-65</u> | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. <u>55</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Maryland</u> | |
| 13. FATHER'S NAME
<u>Edward Ellison</u> | | 14. MOTHER'S MAIDEN NAME
<u>Roslyn Johnson</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. <u>762.5 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
<u>ANTECEDENT CAUSES</u>
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH
(A) <u>Pulmonary Atelectasis</u>
DUE TO
(B) <u>Immaturity</u>
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) <u>(Yes)</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>December 9, 1965</u> 19 <u>to December 9,</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>December 9,</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Lionel Rose</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>12-9-65</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Lionel Rose</u> | | 23D. ADDRESS
M.D. <u>1514 Division Street</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>DEC 16 1965</u> | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY
<u>UNIVERSITY MEDICAL SCHOOL</u> | |
| 24D. LOCATION (City, town, or county) | | 24E. LOCATION (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>DEC 20 1965</u> | | 25B. NAME OF REGISTRAR
<u>DEC 20 1965</u> | | 25C. NAME OF REGIONAL MORTUARY SERVICE - BEND | |

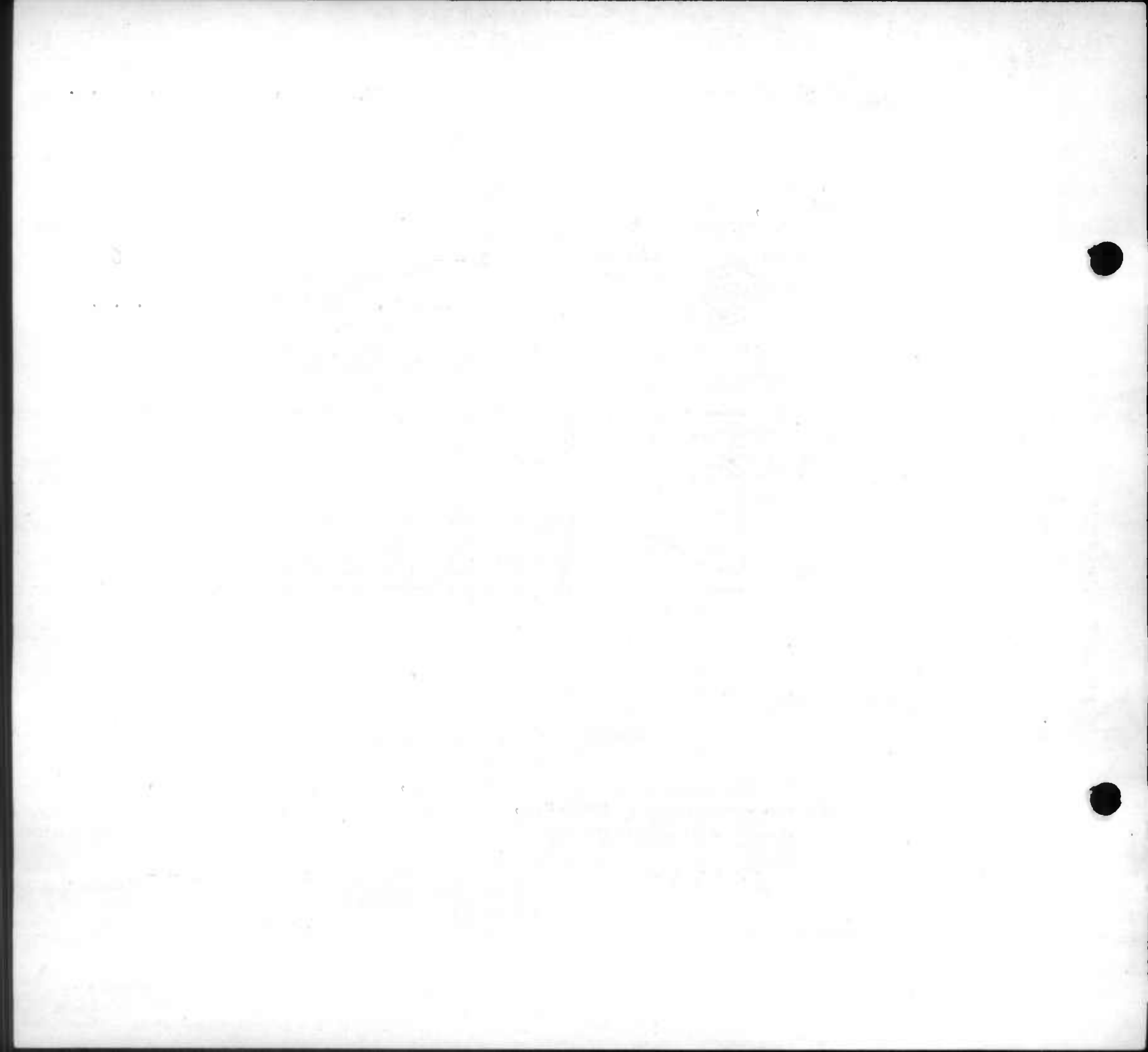


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|------------------------------------|--|---|
| BIRTH NO. <u>65-30291-12918</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>65 12918</u> | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Boy</u>
<u>Baby of Elva Lynette Small</u> | | 2. DATE AND HOUR OF DEATH
<u>December 5, 1965</u> <u>8:05 P.M.</u> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>Provident Hospital</u>
<u>1514 Division Street</u>
<u>Baltimore, Maryland</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Maryland</u>
B. COUNTY <u>13-02</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u>
D. STREET ADDRESS (If rural, give location)
<u>2118 Mt. Royal Avenue</u> | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>Negro</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Single</u> | 8. DATE OF BIRTH
<u>12-5-65</u> | 9. AGE (In years last birthday)
<u>6</u> | If Under 1 Yr. Months: Days: Hours: Min.
If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>Randolph Washington</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>Elva Lynette Small</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| 18. <u>762.5</u> I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>Immaturity</u>
(A) DUE TO
<u>Pulmonary atelectasis</u>
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>yes.</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>December 5, 1965</u> to <u>December 5, 1965</u> , that (I) (we) last saw the deceased alive on <u>December 5, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Lionel C. Rose</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>12-8-65</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Lionel Rose</u> | | 23D. ADDRESS
M.D. <u>1514 Division Street</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>DEC 16 1965</u> | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY
<u>UNIVERSITY MEDICAL SCHOOL</u> | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT.
<u>DEC 20 1965</u> | | | |
| 25B. NAME OF REGISTRAR
<u>R. J. S. S. S.</u> | | 25C. MORTUARY SERVICE
<u>BCHD</u> | | | |

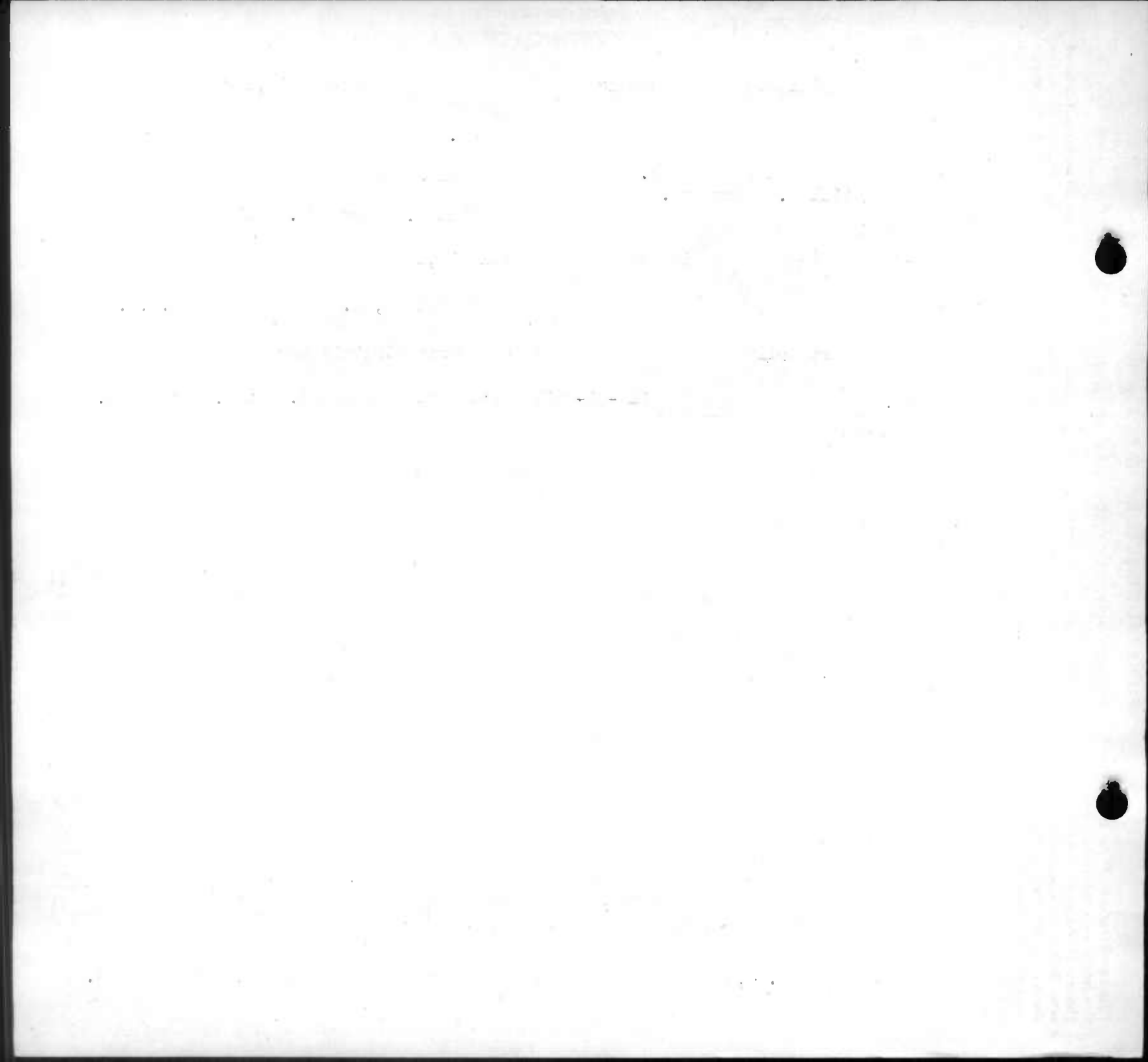


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-----------------------------------|---|--|---|---|
| BIRTH NO. 65 12919 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 65 12919 | |
| 1. NAME OF DECEASED
(Type or Print) Lillieth Norfolk | | | 2. DATE AND HOUR OF DEATH
December 17, 1965 6¹⁵ P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give sheet address or location)
The Wesley Home Inc.
2211 W. Rogers Ave. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY 27-15
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
2211 W. Rogers Ave. 21209 | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
July 28, 1897 | 9. AGE (In years last birthday)
68 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
Cambridge, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Ira Kelly | | | 14. MOTHER'S MAIDEN NAME
Sarah Virginia North | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
219-22-4629 | 17. INFORMANT ADDRESS
The Wesley Home Inc. 2211 W. Rogers Ave. | | |
| 18. 422.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Anterio-sclerotic cardio-vascular disease
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
No | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 18 October 1965 to 17 December 1965 , that (I) (we) last saw the deceased alive on 14 December 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
John W Barnaby | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
18 Dec 65 |
| 23C. PHYSICIAN'S NAME (Type)
JOHN W BARNABY | | | 23D. ADDRESS
M.D. 1531 E North Ave Baltimore Md 21213 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
Dec. 20, 1965 | 24C. NAME OF CEMETERY or CREMATORY
Lorraine Cemetery | | 24D. LOCATION (City, town, or county) (State)
Woodlawn, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 25B. NAME OF REGISTRAR
Robert E. [Signature] | | 25C. FUNERAL DIRECTOR ADDRESS
Wm. F. Tickner & Sons N & Pa. Aves. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|---|--|---|
| BIRTH NO. 65 12920 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 65 12920 | |
| 1. NAME OF DECEASED
(Type or Print) Florence EILAU BAMBERGER | | | 2. DATE AND HOUR OF DEATH
DEC. 18, 1965 9:00 A. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
44 UNION MEMORIAL HOSP. | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MD.
B. COUNTY 14-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
The MARLBOROUGH APTS. - EUTAW PLACE W. | | |
| 5. SEX
F | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
NEVER MARRIED | 8. DATE OF BIRTH
10/19/1886 | 9. AGE (In years last birthday)
79 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
PROFESSOR | | 10B. KIND OF BUSINESS OR INDUSTRY
EDUCATION | | 11. BIRTHPLACE or foreign country
MARYLAND | |
| 13. FATHER'S NAME
ANSEL BAMBERGER | | | 14. MOTHER'S MAIDEN NAME
HANNAH EILAU | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
216-46-1048 | | 17. INFORMANT ADDRESS
MISS JENNIE BAMBERGER - SAME | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) MYOCARDIAL INFARCTION
DUE TO
(B) HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DIS.
DUE TO
(C) _____
INTERVAL BETWEEN ONSET AND DEATH
3-4 HRS.
10 YEARS | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
ASTHMATIC BRONCHITIS | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from DEC. 10 19 65 to DEC. 18 19 65 , that we (we) last saw the deceased alive on DEC. 18 19 65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. us (We) (did) the view the body after death. | | | | | |
| 23A. SIGNATURE
L. Evan Custer | | | | 23B. DATE SIGNED
Dec. 18, 1965 | |
| 23C. PHYSICIAN'S NAME (Type)
L. Evan Custer | | 23D. ADDRESS
M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Cremation | | 24B. DATE
12/20/65 | | 24C. NAME OF CEMETERY or CREMATORY
Greenmount | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 25B. NAME OF REGISTRAR
R. L. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS
William J. Dickner Sons North + Pa Ave | |

1. The first part of the report
is devoted to a general
description of the
area and the
methods used in the
survey.

The second part of the report
contains a detailed
description of the
results of the survey.

The third part of the report
contains a detailed
description of the
conclusions of the survey.

1
M 635

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 12921 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12921

M.E. CASE NO.

| | | | | | |
|---|-------------------------|--|---|--|--|
| 1. NAME OF DECEASED
(Type or Print) Charles RICHARD MARTIN | | | 2. DATE AND HOUR PRONOUNCED DEAD
12/17/65 11:45 p. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Union Memorial Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 12-02
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
3003 N. Charles St. 18 | | |
| 5. SEX
male | 6. RACE
white | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
March 23, 1899 | | 9. AGE (In years
last birthday) 66 |
| 10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)
Lawyer and Professor | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Charles Richard Martin | | | 12. CITIZEN OF
WHAT COUNTRY?
U.S.A. | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)
Yes World 1 | | | 16. SOCIAL
SECURITY NO.
220-22-4724 | | 17. INFORMANT
Mrs. Charles R. Martin |
| | | | ADDRESS
as above | | |

| | | | | | | | |
|-----------------------|--|--|---|--|---|---|--|
| MEDICAL CERTIFICATION | 18. CAUSE OF DEATH
E 903.13
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)
Craniocerebral injury
(A) DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.
(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.
Fatty liver | | | | | INTERVAL BETWEEN
ONSET AND DEATH | |
| | 19A. DATE OF OPERATION
12 | | 19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | 20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?
yes | |
| | 21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)
street | | 21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?
sidewalk unit blk. E 30th St. 12-02 | | |
| | 21D. TIME
OF INJURY
(APPROX.)
12 16 65 5:05 p. | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE
AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
tripped and fell on street | | |
| | 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion
resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>

CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 12/18/65 | | | | | | |
| | 23A. BURIAL CREMATION,
REMOVAL (Specify)
Burial | | 23B. DATE
Dec. 20 1965 | | 23C. NAME of CEMETERY or CREMATORY
St. Johns | | |
| | 24A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 24B. NAME OF REGISTRAR
Robert E. Spitz | | 24C. FUNERAL DIRECTOR
William J. Dickner - Sons North Pa. Ave | | |
| | 23D. LOCATION
(City, town, or county) (State)
Warsaw Virginia | | | | | | |
| | 24D. ADDRESS | | | | | | |

WALLLEY BONGE

44-60-13 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

44-60-13
65 12922

BIRTH NO.

65 12922

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Belinda Newsome

2. DATE AND HOUR OF DEATH

12-17-65

6:05 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1601 Carwell St. #21218

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

8-31-65

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

3 14

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Never worked

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or, unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS-BCH-4940 Eastern Avenue #21224

18. 340.01

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Bacterial meningitis - Hemophylus
influenza 6

4 days

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At
Work ☐Not While
At Work ☐22. I certify that (I) (this hospital) attended the deceased from 12-16-65 19 to 12-17 19 65
that (I) (we) last saw the deceased alive on 12-17 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

12-17-65

23C. PHYSICIAN'S
NAME (Type)

Dr. Louis F. Fine

23D. ADDRESS

M.D.

BCH-4940 Eastern Avenue, Baltimore, Md.

24A. BURIAL CREMATION, 24B. DATE
REMOVAL (Specify)

Burial

12/21/65

24C. NAME OF CEMETERY or CREMATORY

Meadowridge

24D. LOCATION

(City, town, or county)

(State)

Elkridge, Maryland

25A. DATE REC'D BY HEALTH DEPT.

DEC 20 1965

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

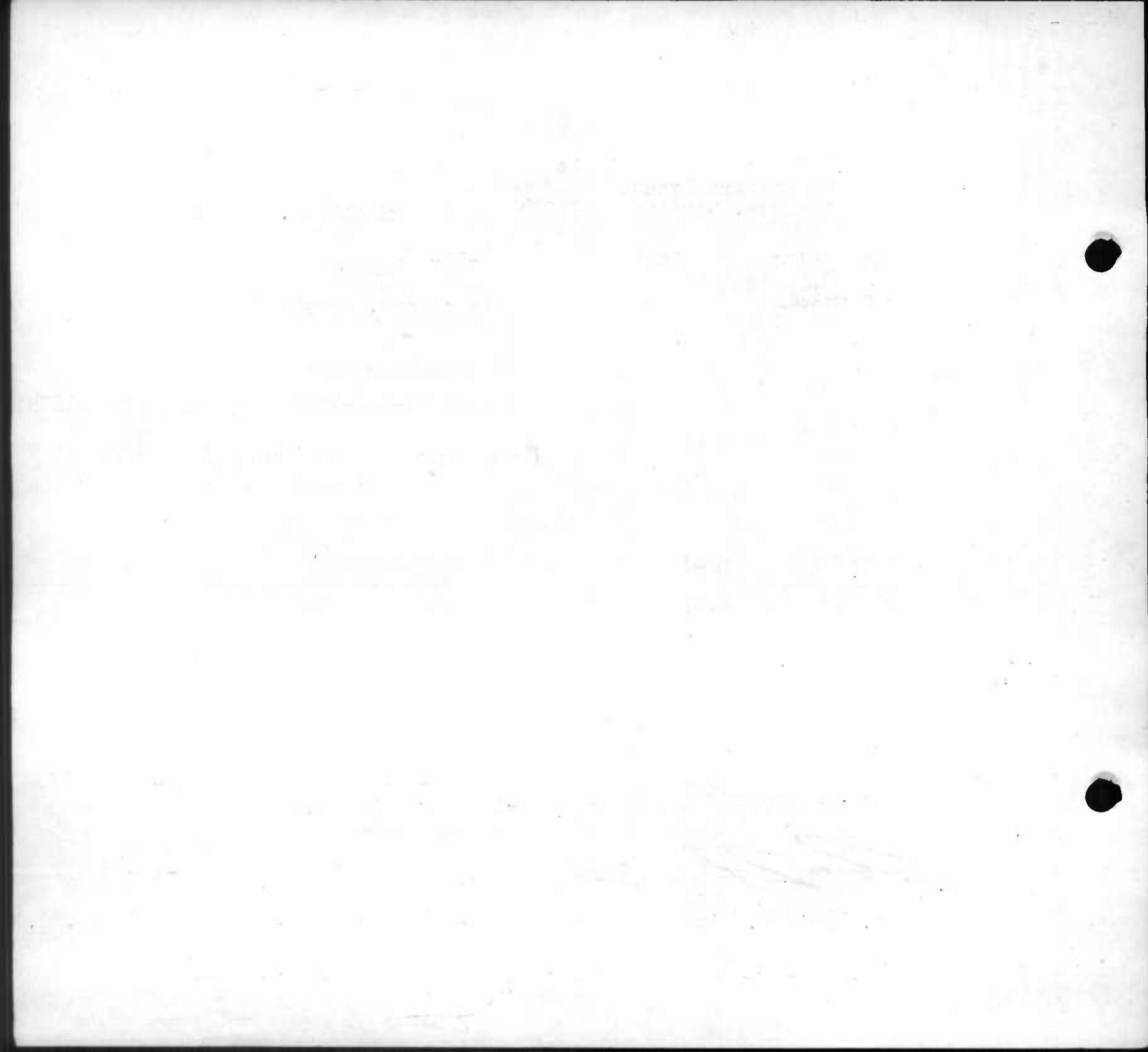
ADDRESS

William J. Dickner + Sons North + Pa. Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

LA-3-4321



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|---|------------------------------------|---|---|
| BIRTH NO. <u>5</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>65 12923</u> | |
| M.E. CASE NO. <u>65 12923</u> | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>AVARA Samuel R.</u> | | 2. DATE AND HOUR OF DEATH
<u>12-16-65</u> <u>5.00 P. M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>Bon Secours Hosp.</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore 28</u> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<u>310 Whitfield Road</u> | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>married</u> | 8. DATE OF BIRTH
<u>10-4-06</u> | 9. AGE (In years
lost birthday)
<u>59</u> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>NONE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Balto. Md.</u> | |
| 13. FATHER'S NAME
<u>Salvatore AVARA</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>215 01 1411</u> | | 17. INFORMANT ADDRESS
<u>Joseph M. Avara, 310 Whitfield Rd</u> | |
| 18. <u>416X1</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH

(A) <u>MULTIPLE EMBOLI TO BRAIN, LUNGS, KIDNEY</u>
DUE TO

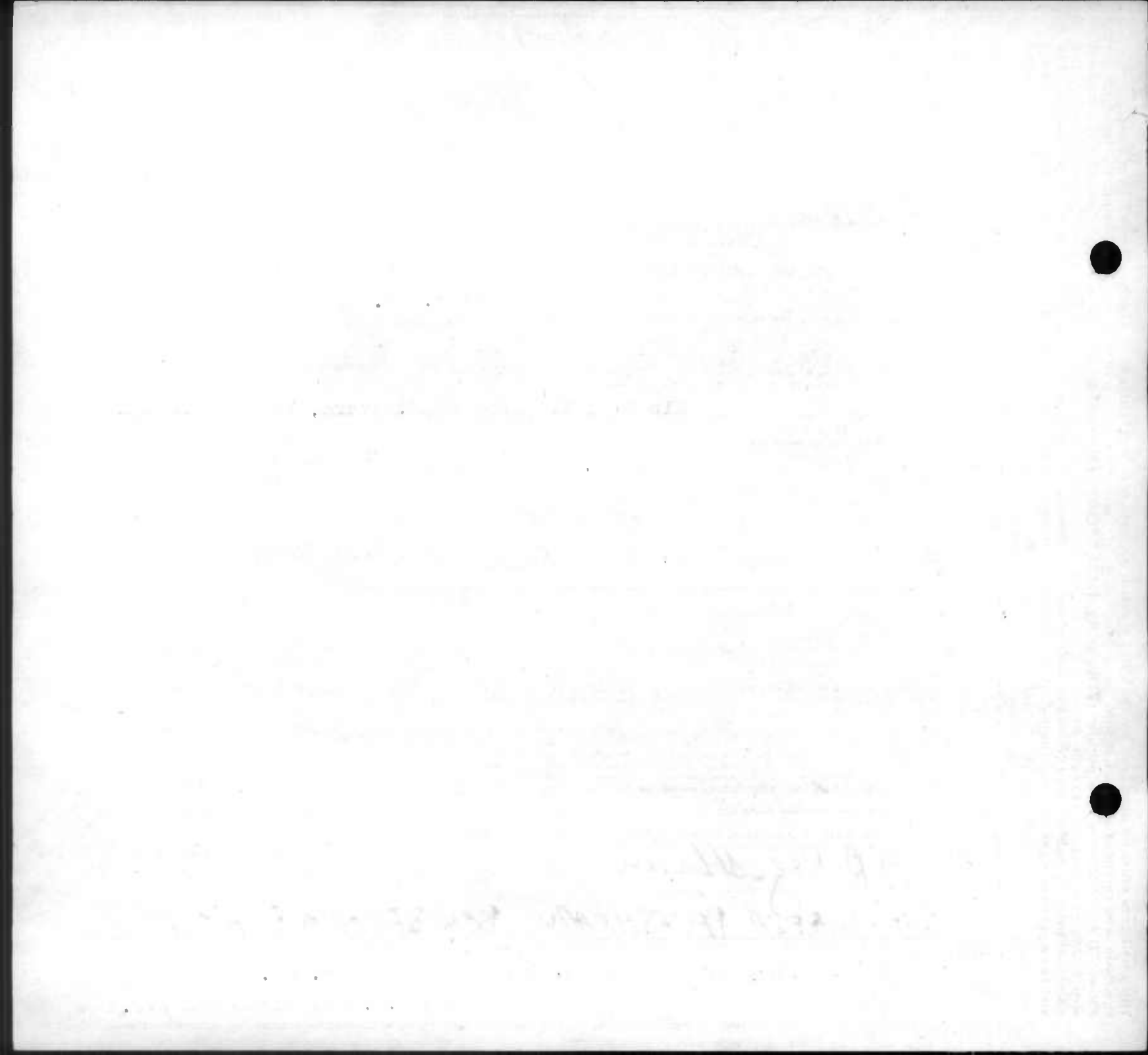
(B) <u>BACTERIAL ENDOCARDITIS</u>
DUE TO

(C) <u>RHEUMATIC HEART DISEASE</u> | | INTERVAL BETWEEN ONSET AND DEATH

<u>4 WEEKS</u>

<u>4 WEEKS</u>

<u>OVER 5 YRS</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>W</u> (this hospital) attended the deceased from <u>11-13-1965</u> to <u>12-16-1965</u> , that <u>W</u> (we) last saw the deceased alive on <u>12-16-1965</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>W</u> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>H.R. Pezeshtarian</u> | | M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>12/16/65</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>GHOLAM REZA PEZESHKIAN</u> | | 23D. ADDRESS
<u>BON SECOURS HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>12/20/65</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>New Cathedral</u> | |
| 24D. LOCATION
<u>Balto. Md.</u> | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>DEC 20 1965</u> | | 25B. NAME OF REGISTRAR
<u>Witzke, F.D.</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>4101 Edmondson Ave.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>65 12924</u> | |
|---|---------------------------|---|--|---|--|--|---|
| BIRTH NO. <u>65 12924</u> | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>SHIPPY, WILLIAM</u> | | 2. DATE AND HOUR OF DEATH
<u>12/17/65</u> <u>9:20 P.</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>South Baltimore General Hospital</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <u>Maryland</u>
B. COUNTY <u>23-01</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u>
D. STREET ADDRESS (If rural, give location)
<u>136 W. Cross Street</u> | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>Colored</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>2/28/187</u> | 9. AGE (In years last birthday)
<u>78</u> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>longshoreman - Retired</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>South Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 13. FATHER'S NAME
<u>Jerry Shippy</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Phyllis Dawkins</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT
<u>ELWEASE SHIPPY 136 W. CROSS ST</u> | | | | |
| 18. <u>5-20-21</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) <u>MESENTERIC THROMBOSIS</u>
DUE TO
(B) _____
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<u>79 HRS</u> | |
| | | | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Inotify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12-17-65</u> 19 <u>65</u> to <u>12-17</u> 19 <u>65</u> , that (s) (we) last saw the deceased alive on <u>12-17</u> 19 <u>65</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Edward S. Hoffman</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>12-18-65</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>EDWARD S. HOFFMAN</u> | | | | 23D. ADDRESS
M.D. <u>1213 Light St. Balto. Md 21230</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>12/22/65</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>MT Auburn</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>DEC 20 1965</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Johnson</u> | | 25C. FUNERAL DIRECTOR
<u>Charles A. Rice 6614 Barne St</u> | | ADDRESS | |

EDWARD J. HOFFMAN

1000 1st St. N. W. Wash. D. C.

July 20, 1914

My dear Mr. Hoffman

I have just received

your letter of the 15th

Phyllis Dowling

2nd Class

8/18/14

130 W. 1st St. N. W.

Washington

D. C.

OFFICE OF THE

1914

1914

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | |
|--|--|---------------------|--|--|--|--|--|---|---|---|--|---|--|
| BIRTH NO. 65 12925 | | | | | | CERTIFICATE OF DEATH | | | Registered No. 65 12925 | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Perkins, Merlee Sylvester</i> | | | | | | 2. DATE AND HOUR OF DEATH
<i>12:45 12-12-65</i> <i>1A</i> M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>University Hospital</i> | | | | | | A. STATE <i>Maryland</i> B. COUNTY <i>15-02</i> | | | | | | | |
| (If not in hospital or institution, give street address or location) | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | | | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location)
<i>1643 N. Fulton Ave.</i> | | | | | | | |
| 5. SEX
<i>M</i> | | 6. RACE
<i>N</i> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>Married</i> | | 8. DATE OF BIRTH
<i>10-21-09</i> | | 9. AGE (In years, lost birthday)
<i>56</i> | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Retired "Feeder"</i> | | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country)
<i>Virginia</i> | | | | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | | | | | | | | | | | |
| 13. FATHER'S NAME
<i>Robert Perkins</i> | | | | | | 14. MOTHER'S MAIDEN NAME
<i>Bertha White</i> | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | | 16. SOCIAL SECURITY NO.
<i>217-05-7451</i> | | | 17. INFORMANT
<i>Leda P. Perkins (wife)</i> ADDRESS <i>S/A</i> | | | | |
| 18. <i>305 XI</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | CAUSE OF DEATH
(A) <i>Alzheimer's Disease</i> DUE TO
(B) <i>Massive collapse, Left Lung</i> DUE TO
(C) <i>Shock</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>2 years</i>
<i>1 1/2 mos</i>
<i>1 1/2 mos.</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (H) (this hospital) attended the deceased from <i>11-1-65</i> 19 to <i>12-17</i> 19 <i>65</i> , that (H) (we) last saw the deceased alive on <i>12-17</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 23A. SIGNATURE
<i>D-B Arnold Platt</i> | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED
<i>12-17-65</i> | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | 23D. ADDRESS
M.D. <i>University Hospital</i> | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | | 24B. DATE
<i>12/20/65</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Mt. Auburn</i> | | | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>DEC 20 1965</i> | | | | 25B. NAME OF REGISTRAR
<i>Robert E. Johnson</i> | | | | 25C. FUNERAL DIRECTOR
<i>Arington J. Phillips</i> ADDRESS <i>1727 N. Mount</i> | | | | | |

General Hospital

M. W. [unclear]

Handwritten notes

Handwritten notes

Handwritten notes
10-11-01
20

Handwritten notes

Handwritten notes

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Handwritten notes

13-11

14-11-01

15-11

15-11-01

Handwritten notes

Handwritten notes

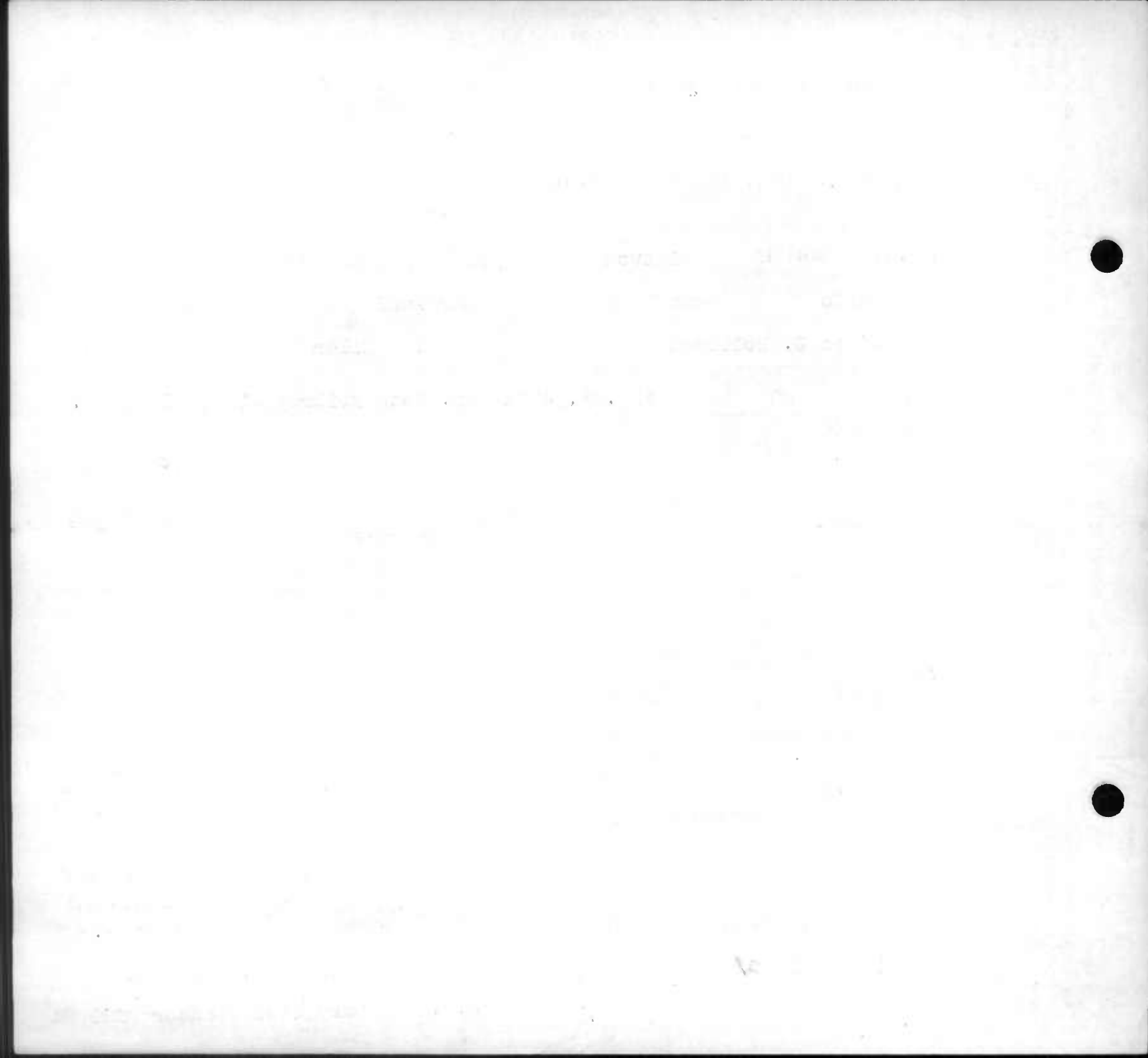
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>65 12926</u> | |
|--|-------------------------|---|--|---|--|--|--|
| BIRTH NO. <u>65 12926</u> | | M.E. CASE NO. <u>65 12926</u> | | 1. NAME OF DECEASED
(Type or Print) <u>JULIA A. LILLEY</u> | | 2. DATE AND HOUR OF DEATH
<u>DEC. 18, 1965</u> <u>7:30 P. M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>LUTHERAN HOSPITAL OF MARYLAND</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY <u>28-02</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u>
D. STREET ADDRESS (If rural, give location)
<u>2908 OAKHILL AVE.</u> | | | |
| 5. SEX
<u>FEMALE</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Widowed</u> | 8. DATE OF BIRTH
<u>5/20/881/1881</u> | 9. AGE (In years last birthday)
<u>84</u> | If Under 1 Yr. Months: Days: Hours: Min.
If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Houswife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>own home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>James O. Holbrook</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>? Eiler</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>216.09.9473A</u> | | 17. INFORMANT'S ADDRESS
<u>Mr. Seth Holbrook 7307 Blair Rd.</u> | | | |
| 18. <u>443X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) <u>CONGESTIVE HEART FAILURE</u>
DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
<u>10 DAYS</u> | |
| | | | | (B) <u>HYPERTENSIVE CARDIO-VASCULAR</u>
DUE TO <u>DISEASE</u> | | <u>3 YEARS</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>DEC. 11</u> 19 <u>65</u> to <u>DEC. 18</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>DEC. 18</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Daniilo M. Coronel, M.D.</u> | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>DEC. 18, 1965</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>DANILO M. CORONEL, M.D.</u> | | | | 23D. ADDRESS
<u>LUTHERAN HOSPITAL OF MARYLAND
730 ASHBURTON CT. BALTO. MD. 21216</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>12/24/65</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Druid Ridge</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Pikesville, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>DEC 20 1965</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Salsbery</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>J.T. Stansbury 6411 Windsor Mill Rd</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 12927 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 12927 | |
|---|--|---|--|--|--|---|--|---|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) VERONA ZOELLER | | VERONA ZOELLER | | 2. DATE AND HOUR OF DEATH
12-16-65 2 7 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE Dundalk 5300 | | D. STREET ADDRESS (If rural, give location)
8716 NORTHVIEW Rd. 21222 | |
| 5. SEX
FEMALE | | 6. RACE
WHITE | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | | 8. DATE OF BIRTH
2-3-1900 | | 9. AGE (In years last birthday)
65 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
NEW JERSEY | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
WILLIAM TITUS | | | | 14. MOTHER'S MAIDEN NAME
MAGGIE FISK | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No None | | | | 16. SOCIAL SECURITY NO.
215-07-4168 | | 17. INFORMANT ADDRESS
Husband, Mr. Wm. J. Zoeller, #4, a, b, c, d. | | | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) DUE TO Myocardial Infarction, Acute
(B) DUE TO ARTERIO SCLEROTIC HEART DISEASE
(C) DUE TO Pneumothorax and collapse of Left Lung | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-15 19 65 to 12-16 19 65, that (I) (we) last saw the deceased alive on 12-16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
M. A. Tolentino | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
12/16/65 | |
| 23C. PHYSICIAN'S NAME (Type)
CARLINO A. TOLENTINO | | | | 23D. ADDRESS
CHURCH HOME & HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Dec-20-1965 | | 24C. NAME OF CEMETERY OR CREMATORY
Oak Lawn | | 24D. LOCATION (City, town, or county) (State)
7225 Eastern Ave. Balto. Md. 21224 | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 25B. NAME OF REGISTRAR
John J. Buda | | 25C. FUNERAL DIRECTOR ADDRESS
JOHN J. BUDA, 7922 Wise Ave. Dundalk, Md. | | | | | |

OFFICE
2100
2100
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2100
2100

65 12928

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12928

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FRANCIS

KANE

2. DATE AND HOUR PRONOUNCED DEAD

December 16, 1965

7:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1326 McCulloh Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1326 McCulloh Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

June 1, 1923

9. AGE (in years
last birthday)

42

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Contractors

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frank Somerville

14. MOTHER'S MAIDEN NAME

Julia Kane

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

Link

17. INFORMANT

Christina Mitchell 3516 Clifton Ave.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Fatty Liver and Cirrhosis.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/17/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/21/65

23C. NAME of CEMETERY or CREMATORY

Arboretum New Pk. Balto. Md.

23D. LOCATION

(City, town, or county)

(State)

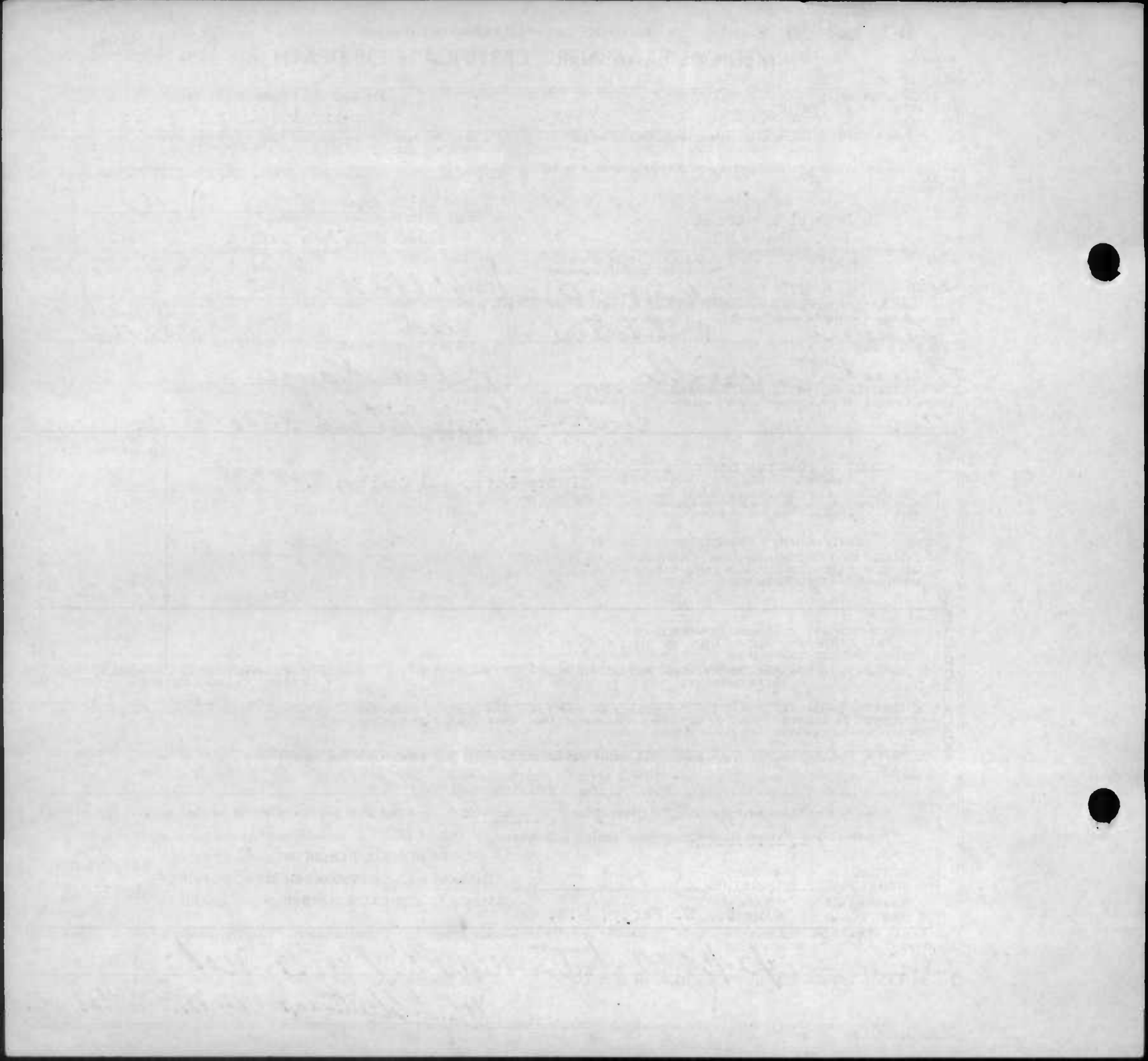
24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Wm. J. Glatwain 1701 McCulloh St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 12929 | |
|---|--|--|--|--|---|--|--|
| BIRTH NO. 65 12929 | | M.E. CASE NO. 65 12929 | | 1. NAME OF DECEASED
(Type or Print) ALICE KING | | 2. DATE AND HOUR OF DEATH
12-18-65 5:35 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

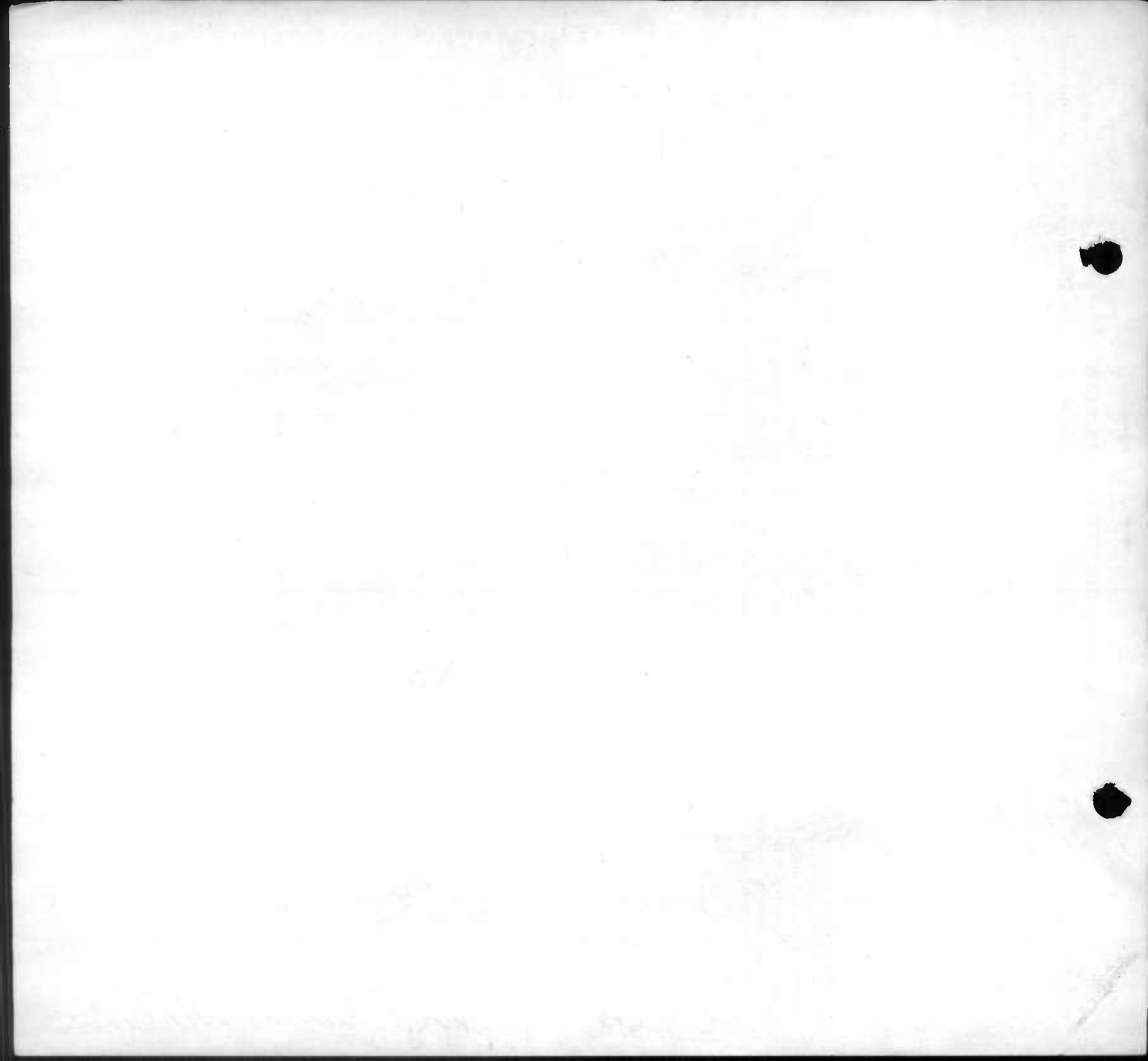
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE City
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21213
D. STREET ADDRESS (If rural, give location) 1407 FEDERAL ST. 9-09 | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 8/6/13 | 9. AGE (In years last birthday) 52 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Juratian | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Crewe Virginia | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME HENRY DANIELS | | 14. MOTHER'S MAIDEN NAME Unknown | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Fred King | | ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH Chronic Inflammation
(A) DUE TO

ANTECEDENT CAUSES Mixed Mesodermal Tumor of Uterus
(B) DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Metastatic Lesions - lung, peritoneum
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Renal Failure | | | | INTERVAL BETWEEN ONSET AND DEATH dx since 8-22-65 | | | |
| 19A. DATE OF OPERATION 174X I | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (N) (this hospital) attended the deceased from 12-9-1965 to 12-18-1965 , that (I) (we) last saw the deceased alive on 12-17-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Stephen M. Kranz | | | | 23B. DATE SIGNED 12-18-65 | | | |
| 23C. PHYSICIAN'S NAME (Type) DR. STEPHEN M. KRANZ | | 23D. ADDRESS JOHNS HOPKINS HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY Crewe Virginia | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 20 1965 | | 25B. NAME OF REGISTRAR Fred T. Ellickson | | 25C. FUNERAL DIRECTOR ADDRESS 1129 N. Calver St | | | |



1
5-540

65 12930

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12930

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN RAYMOND SMALL

2. DATE AND HOUR PRONOUNCED DEAD

12/18/65 1:30 p.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1826 E. Madison St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1826 E. Madison St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Separated

8. DATE OF BIRTH

June 14, 1925

9. AGE (In years
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Littleton N. Carolina

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War II

16. SOCIAL
SECURITY NO.

17. INFORMANT

Bessie Fitts

ADDRESS

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Massive spontaneous intra-cerebral hemorrhage

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Hypertensive cardiovascular disease

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN DETERMINING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK

NOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

12/19/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Dec 23/65

23C. NAME OF CEMETERY or CREMATORY

Bald, Nord Cem.

23D. LOCATION

5501 Frederick Ave.

24A. DATE REC'D BY HEALTH DEPT.

DEC 20 1965

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

Milton E. Ellickson 1129 N. Carlton St

ADDRESS

THE NEW YORK PUBLIC LIBRARY

APR 11 1905
LIBRARY OF THE
NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION
500 5TH AVENUE
NEW YORK

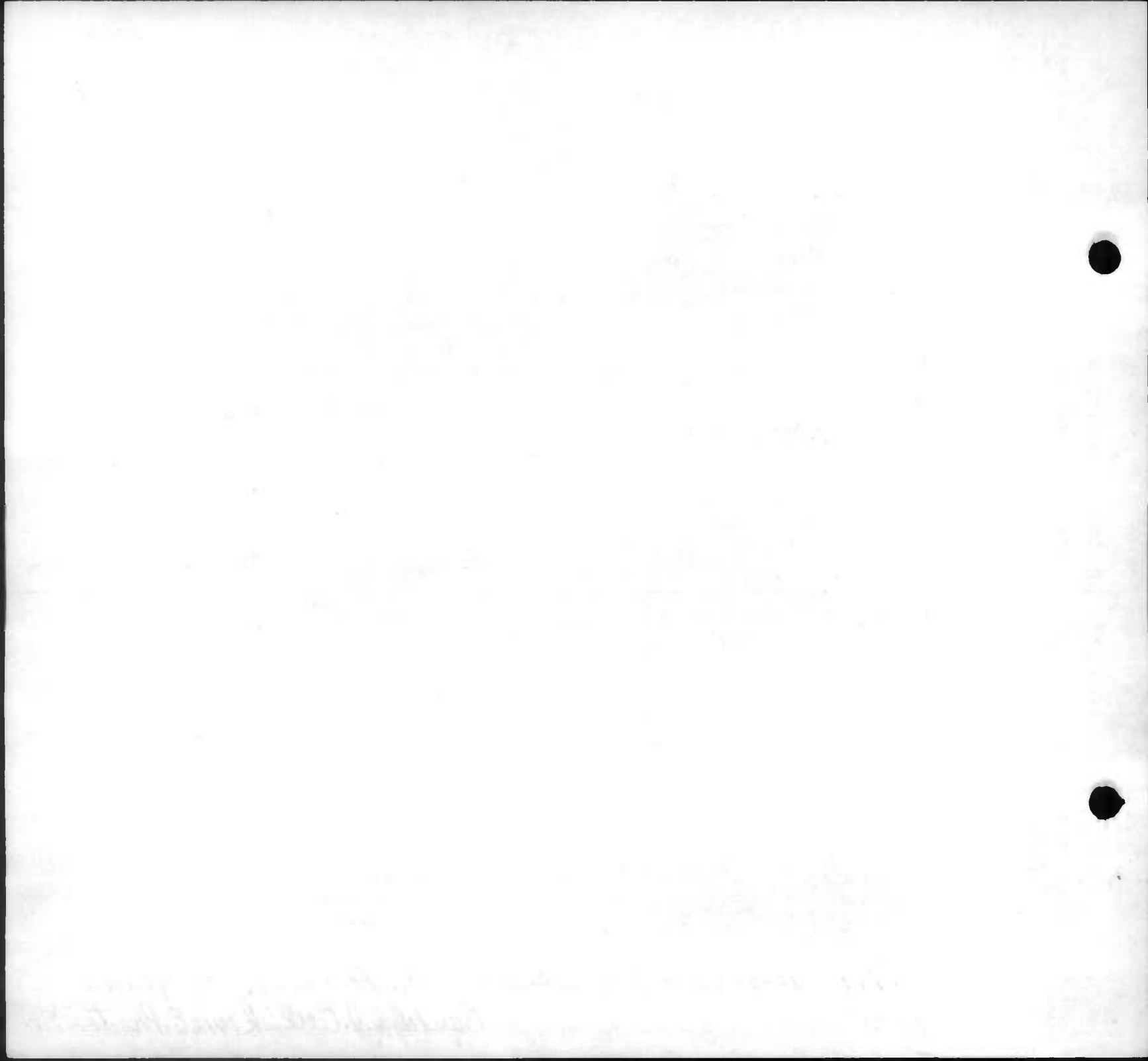
THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION
500 5TH AVENUE
NEW YORK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|-------------------------|---|--|--|---|
| 65 12931 | | CERTIFICATE OF DEATH | | 65 12931 | |
| 1. NAME OF DECEASED
(Type or Print) Bertie Lee Hayes | | | 2. DATE AND HOUR OF DEATH
December 15, 1965 4:37 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Maryland General Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Maryland
B. COUNTY 9-07
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
1565 Carswell St. | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
Jan 20th 1900 | 9. AGE (In years last birthday)
65 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Steelworker | | 10B. KIND OF BUSINESS OR INDUSTRY
Bethlehem Steel | | 11. BIRTHPLACE (State or foreign country)
North Carolina | |
| 13. FATHER'S NAME
John Hayes | | | 14. MOTHER'S MAIDEN NAME
Mary Morley | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
217-01-0365 | | 17. INFORMANT
Mrs. Bertie Hayes 1565 Carswell St. | |
| 18. 465X4163X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Cardiac Arrest
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Pulmonary embolus
Probable Arteriosclerotic Heart Disease
with Correlative Heart Failure | | | CAUSE OF DEATH
34 minutes
INTERVAL BETWEEN ONSET AND DEATH
Unknown | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Carcinoma of Lung
Diabetes Mellitus - recently discovered | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Yes | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from 12/14 1965 to 12/15 1965 , that (I) <u>(we)</u> last saw the deceased alive on 12/15 1965 and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Elijah Saunders | | | | 23B. DATE SIGNED
12/15/65 | |
| 23C. PHYSICIAN'S NAME (Type)
ELIJAH SAUNDERS | | | | 23D. ADDRESS
Maryland General Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12-20-65 | | 24C. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Pk. Arbutus, Maryland | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Johnson | | 25C. FUNERAL DIRECTOR
Randolph J. Collick 1412 E. Preston St | | | |



65 12932

BALTIMORE CITY HEALTH DEPARTMENT

65 12932

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ARTHUR LEE GRISINGER

2. DATE AND HOUR PRONOUNCED DEAD

12-12-65

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

25 N. EAST AVENUE

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

25 N. East Avenue

5. SEX

MALE

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

JAN 23, 1918

9. AGE (In years
last birthday)

47

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CARPENTER.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

SAMUEL L. GRISINGER

14. MOTHER'S MAIDEN NAME

EDNA HOLLOWAY

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

MRS. E. LAGNA 164 N. POTOMAC ST.

18.

490X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Lobar pneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Cirrhosis of liver

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Partial - Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-13-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-15-65

23C. NAME OF CEMETERY or CREMATORY

PARKWOOD CEMETERY

23D. LOCATION

(City, town, or county)

(State)

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 20 1965

R. S. Fisher

B. Dabrowski 2118 E. BALTIMORE ST.

Blank lined paper with two punch holes on the right side.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 12933 | |
|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | Registered No. | |
| BIRTH NO.
65 12933 | | DATE AND HOUR OF DEATH
12-13-65 8:50 AM | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Francis Dunnigan</i> | | | |
| 2. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| CERTIFICATE AMENDED
FULL NAME OF HOSPITAL OR INSTITUTION
<i>Fayette Convalescent Home</i>
<i>1105 E Fayette St</i> | | A. STATE
<i>Maryland</i> | | | |
| | | B. COUNTY
<i>Fol</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> <i>24</i> | | | |
| D. STREET ADDRESS (If rural, give location)
<i>2801 Elliott Street</i> | | E. DATE OF BIRTH
<i>7/9/1889</i> | | | |
| 5. SEX
<i>M</i> | | 6. RACE
<i>W</i> | | 9. AGE (In years last birthday)
<i>76</i> | |
| 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED, SEPARATED
<i>Widowed</i> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>RAILROAD RETIRED</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | |
| 13. FATHER'S NAME
<i>John Dunnigan</i> | | 14. MOTHER'S MAIDEN NAME
<i>Julia Ford</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>Mrs. Inez Dunnigan</i> | | ADDRESS
<i>2901 Cold Spring Lane</i> | |
| 18. <i>610X I</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) <i>benign prostatic hypertrophy</i> | | <i>2 years</i> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <i>generalized arteriosclerosis</i> | | <i>several years.</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Feb. 5, 1964</i> to <i>12-13-65</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>Dec. 4, 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>E. Ellsworth Cook</i> | | | | 23B. DATE SIGNED
<i>12-14-65</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>E. Ellsworth Cook</i> | | | | 23D. ADDRESS
<i>M.D.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 24B. DATE
<i>12-16-65</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>New Cathedral Cem.</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Baltimore Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>DEC 20 1965</i> | | 25B. NAME OF REGISTRAR
<i>R. A. E. Jones</i> | |
| 25C. FUNERAL DIRECTOR
<i>B. Dabrowski</i> | | 25D. ADDRESS
<i>514 E. Balt. St.</i> | | | |

V.S. 153

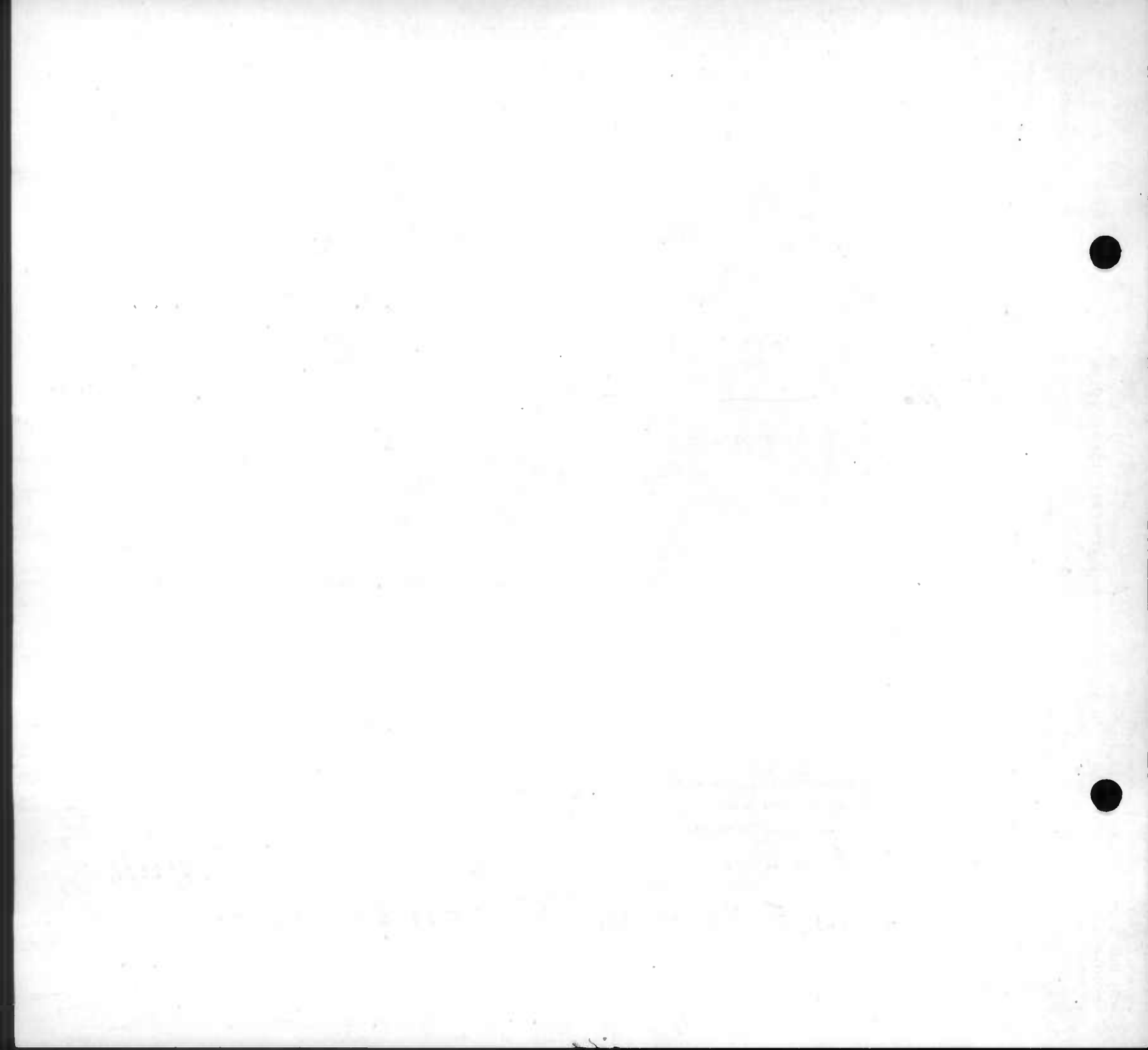
12-27-65

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

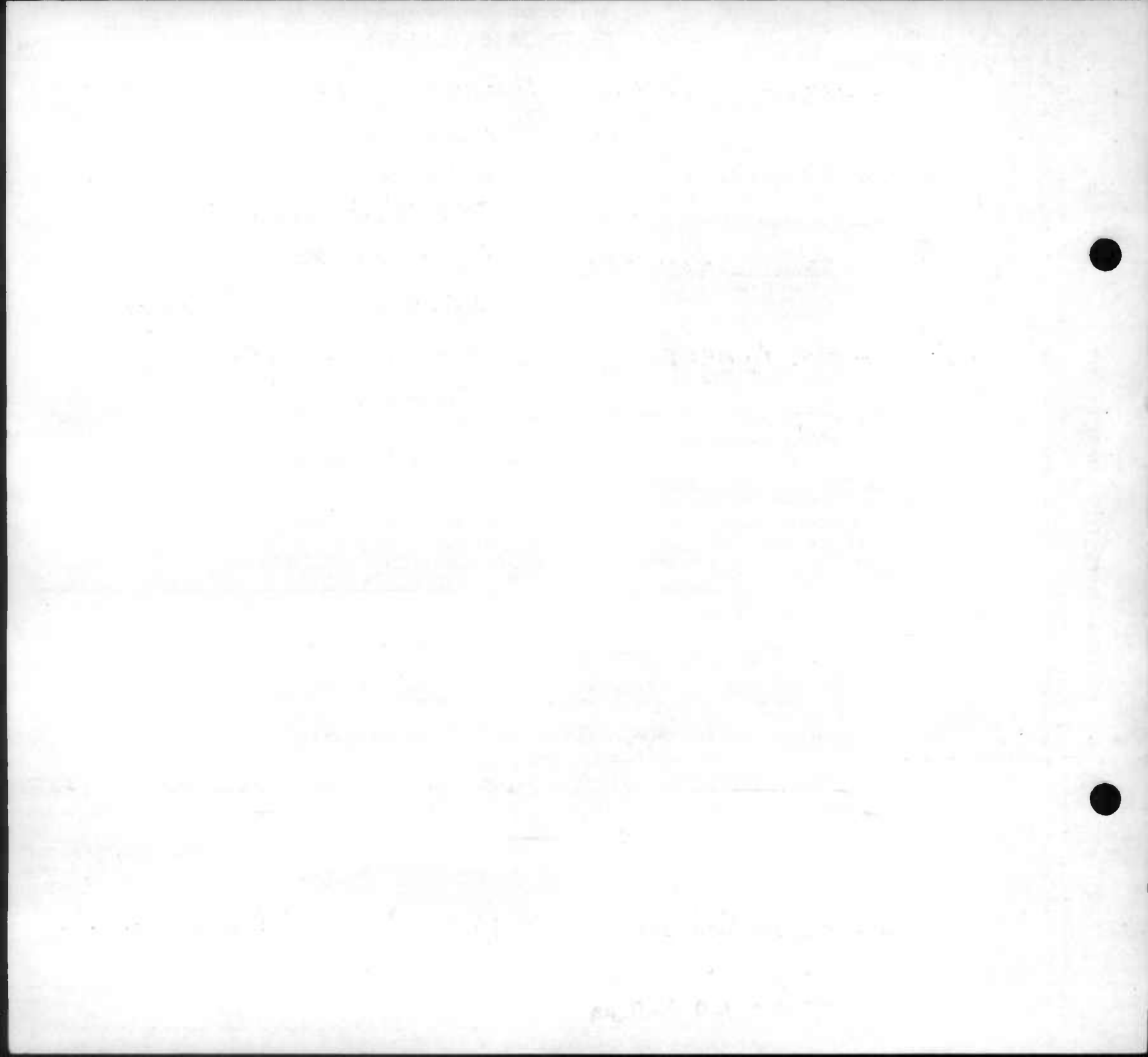
| BIRTH NO. 65 12934 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 12934 | |
|--|------------------|---|------------------------------|---|---|---|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Stanislaus F. Andrzejewski | | | | 2. DATE AND HOUR OF DEATH
December 19th 1965 | | P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
326 South Folcroft Street | | | | A. STATE B. COUNTY
Maryland | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore, 21224 | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
326 South Folcroft Street | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
10/28/92 | 9. AGE (In years lost birthday)
73 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY
Master Plumber | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Stanislaus Andrzejewski | | | | 14. MOTHER'S MAIDEN NAME
Maryanna Putz | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
220-30-1104 | | 17. INFORMANT ADDRESS
Salomea Andrzejewski 326 S. Folcroft Street | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
443X1
CAUSE OF DEATH
H.C.U.D. - R.54
INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/18/65 to 12/18/65, that (I) (we) last saw the deceased alive on 12/18/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
Mitchell F. Kunkowski | | | | 23B. DATE SIGNED
12/20/65 | | | |
| 23C. PHYSICIAN'S NAME (Type)
MITCHELL F. KUNKOWSKI | | | | 23D. ADDRESS
M.D. 2529 EASTERN AVE. #21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12/23/65 | | 24C. NAME OF CEMETERY or CREMATORY
St. Stanislaus Cemetery | | 24D. LOCATION (City, town, or county) (State)
Dundalk Ave-Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 25B. NAME OF REGISTRAR
George E. Johnson | | 25C. FUNERAL DIRECTOR
George A. Weber 705 S. Ann St | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

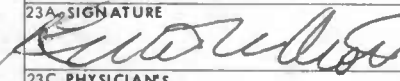
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12935 | |
|---|--|---|--|--|--|
| BIRTH NO. 65 12935 | | CERTIFICATE OF DEATH | | Registered No. 65 12935 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) LEITCH JENNIE HUGHES | | 2. DATE AND HOUR OF DEATH 12-17-65 6:00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY 26-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 347 S NewKirk St. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) North Charles Gen. Hosp. | | 5. SEX F | | 6. RACE W | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) DIVORCED | | 8. DATE OF BIRTH 11-3-1892 | | 9. AGE (In years last birthday) 73 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Illinois | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME HUGHES, Robert | | 14. MOTHER'S MAIDEN NAME Lloyd, Elizabeth | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT CHART ADDRESS | |
| 18. 422.11
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) A.S.C.V.D.-
DUE TO
(B) Congestive heart failure.
DUE TO
(C) Residual Pneumonia.- | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from DEC 14 1965 to DEC 17 1965 , that (I) (we) last saw the deceased alive on 12/17/65 at 6:00 P.M. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Arthur M. Goldira | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12/17/65 | |
| 23C. PHYSICIAN'S NAME (Type) Arthur M. Goldira | | 23D. ADDRESS M.D. 1942 CEDAR LANE # 22 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/20/65 | | 24C. NAME OF CEMETERY or CREMATORY Morland's Mem. | |
| 24D. LOCATION (City, town, or county) (State) Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT. DEC 20 1965 | | 25B. NAME OF REGISTRAR P.O. & E. J. Jones | |
| 25C. FUNERAL DIRECTOR Connelly F.H. | | ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12936 | |
|---|--------------------------|---|---------------------------------|---|--|
| BIRTH NO. 65 12936 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) BRAWNER, HERBERT EUGENE | | 2. DATE AND HOUR OF DEATH
December 16, 1965 4:05 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland
B. COUNTY 26-09 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Veterans Administration Hospital
3900 Loch Raven Blvd.
Baltimore, Maryland 21218 | | D. STREET ADDRESS (If rural, give location)
921 S. Conkling Street | | | |
| 5. SEX Male | 6. RACE Caucasian | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Divorced | 8. DATE OF BIRTH 4/15/03 | 9. AGE (In years last birthday) 62 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Painter | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
James Brawner | | 14. MOTHER'S MAIDEN NAME
Mary Roberts | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 9/28/42 To 3/31/43 | | 16. SOCIAL SECURITY NO.
213-10-8391 | | 17. INFORMANT ADDRESS
V.A. Hospital, Baltimore, Md. 21218 | |
| 18. I 162.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Bronchogenic Carcinoma of lung with widespread metastases | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
23 months | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 16, 1965 to December 16, 1965 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 16, 1965 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (do not) view the body after death. | | | | | |
| 23A. SIGNATURE
 | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
12/16/65 | |
| 23C. PHYSICIAN'S NAME (Type)
KENNETH MOTT | | 23D. ADDRESS
M.D. 3900 Loch Raven Blvd. Baltimore, Md. 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12/20/65 | | 24C. NAME OF CEMETERY or CREMATORY
Balto. National | |
| 24D. LOCATION
Balto. Md. | | 24E. NAME OF REGISTRAR
Robert E. Taylor | | 24F. FUNERAL DIRECTOR
Connolly F. H. 300 MacCar Ave. Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | | | | |

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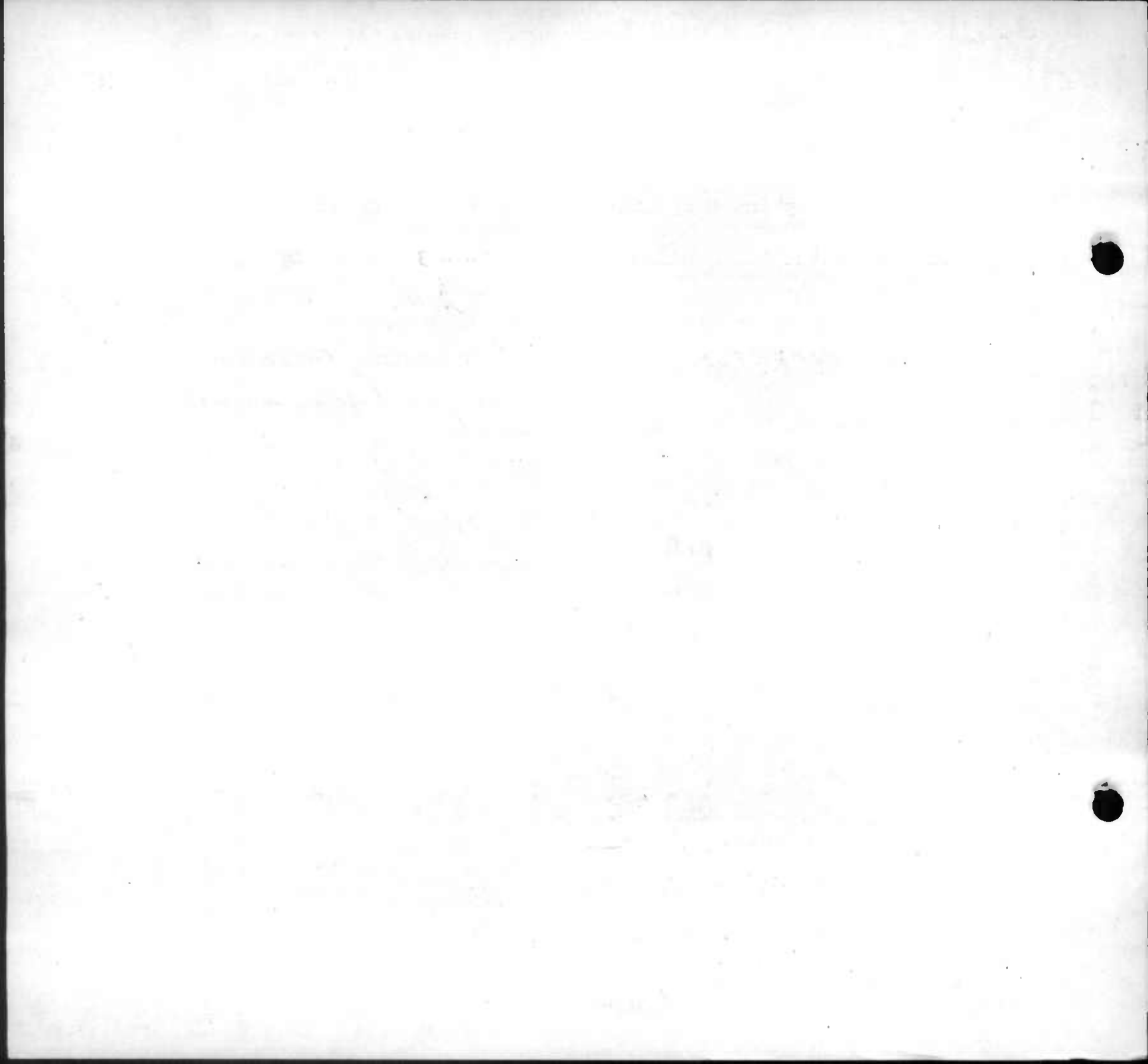
10/10/10

10/10/10

10/10/10

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|-----------------------------------|--|--|---|------------------------------|--|---------------------------------|--|--|--|--|--|--|--|--|--|--|--|------------------|--|--|--|--|--|--|--|--|--|
| 65 12937 | | | | | 65 12937 | | | | | | | | | | | | | | | | | | | | | | | | |
| BIRTH NO. | | | | | Registered No. | | | | | | | | | | | | | | | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | | 2. DATE AND HOUR OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | |
| Maude Ford | | | | | 12-16-65 9:15 a.m. | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | | | | | | | | | | | | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | A. STATE B. COUNTY | | | | | | | | | | | | | | | | | | | | | | | | |
| The Johns Hopkins Hospital | | | | | Maryland Baltimore | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | RT #1 Box 553 A | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | | | | | | | | | | | | | | | | | | | | |
| Female | | White | | Widow | | 7-8-93 | | 72 | | | | | | | | | | | | | | | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | Md. | | U.S.A. | | | | | | | | | | | | | | | | | | | | | | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | |
| Elias ROBERTSON | | | | | Catherine GOSNELL | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | Children (same as above) | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. 153.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| ANTECEDENT CAUSES | | | | | (A) UPPER G-i Bleeding + pulmonary Embolus
DUE TO | | | | | | | | | | | | | | | | | | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) GASTRIC/ES. PHARYNGEAL ERASION?
DUE TO | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | (C) CARCINOMA of TRANSVERSE COLON | | | | | | | | | | | | | | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | Left femoral Hernia | | | | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 3/12/13/65 | | | | | CA of TRANSVERSE COLON | | | | | YES | | | | | | | | | | | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/9 1965 to 12/16 1965, that (I) (we) last saw the deceased alive on 12/16 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | 23A. SIGNATURE | | | | | | | | | | 23B. DATE SIGNED | | | | | | | | | |
| Walter D. Gundel | | | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> HOUSE Staff Phys. <input checked="" type="checkbox"/> | | | | | | | | | | 12/16/65 | | | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | | | | | 23D. ADDRESS | | | | | | | | | | | | | | | | | | | |
| Walter D. Gundel | | | | | | | | | | M.D. The Johns Hopkins Hospital | | | | | | | | | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | | 24B. DATE | | | | | 24C. NAME of CEMETERY or CREMATORY | | | | | 24D. LOCATION (City, town, or county) (State) | | | | | | | | | | | | | | |
| Burial | | | | | 12/20/65 | | | | | Greenwood Cemetery | | | | | Balt. Co. Md. | | | | | | | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | | 25B. NAME OF REGISTRAR | | | | | 25C. FUNERAL DIRECTOR | | | | | ADDRESS | | | | | | | | | | | | | | |
| DEC 20 1965 | | | | | Robert E. F. H. | | | | | Gunnell F. H. | | | | | 300 Moore | | | | | | | | | | | | | | |

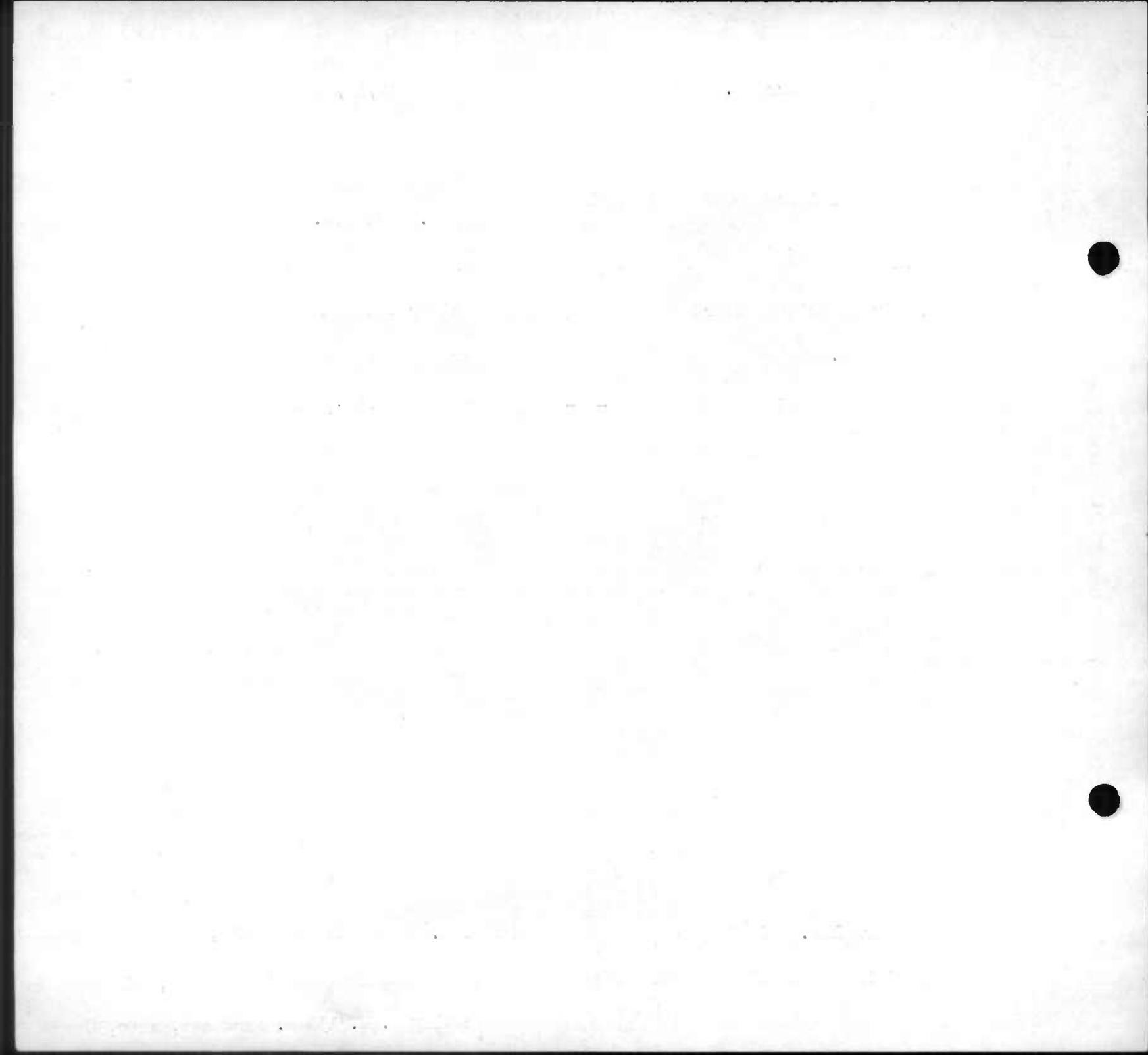


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 12938 | |
|---|------------------|---|-----------------------------|--|--|
| CERTIFICATE OF DEATH | | | | Registered No. 65 12938 | |
| BIRTH NO.
65 12938 | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH
12/18/65 | |
| 1. NAME OF DECEASED
(Type or Print)
Harry E. Busick | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
South Baltimore General Hospital | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE
Md | | B. COUNTY
2404 | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | D. STREET ADDRESS (If rural, give location)
409 E. Fort Ave. | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
8/29/95 | 9. AGE (In years last birthday)
70 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Maritime Guard |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Md | | 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
George L. Busick | |
| 14. MOTHER'S MAIDEN NAME
Mary Elliott | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WW I | | 16. SOCIAL SECURITY NO.
211-18-1822 | |
| 17. INFORMANT
Mrs Anna Busick, Same as line D | | ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Acute Coronary Thrombosis
Antecedent Causes
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Pulmonary Emphysema? | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
acute | |
| MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1962 to Dec 13 1965, that (I) (we) last saw the deceased alive on Dec 13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Israel J. Feinglos | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
12/18/65 | |
| 23C. PHYSICIAN'S NAME (Type)
Israel J. Feinglos | | 23D. ADDRESS
2002 E. Pratt St. Baltimore, Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12/21/65 | | 24C. NAME OF CEMETERY or CREMATORY
Holy Cross Cemetery | |
| 24D. LOCATION
Anne Arundel County, Md | | 24E. STATE
Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 25B. NAME OF REGISTRAR
McCully, F. G. | | 25C. FUNERAL DIRECTOR
130 E. Fort Ave, Balto, 30 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|-------------------------|--|--------------------------------------|--|---|
| BIRTH NO.
65 12939 | | CERTIFICATE OF DEATH | | 65 12939 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Detmore, Neil C.</i> | | 2. DATE AND HOUR OF DEATH
<i>12-18-65 4:00 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) | | 5. STATE | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>DoA - South Baltimore General Hospital</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Maryland</i> | | D. STREET ADDRESS (If rural, give location)
<i>13726 St. Victor Street, Baltimore Md.</i> | |
| 5. SEX
<i>Female</i> | 6. RACE
<i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>SINGLE</i> | 8. DATE OF BIRTH
<i>6-25-1890</i> | 9. AGE (In years last birthday)
<i>75</i> | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Retired Mercy Hosp. PA.</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>PA.</i> | | 11. BIRTHPLACE (State or foreign country)
<i>PA.</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>USA.</i> | | 13. FATHER'S NAME
<i>George Detmore</i> | | 14. MOTHER'S MAIDEN NAME
<i>Margaret Bryan</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No.</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>Family</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<i>422.1 I</i> | | CAUSE OF DEATH
<i>Arteriosclerotic Cardiovascular Disease</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | DUE TO | | | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from <i>12/15/65</i> 19 to <i>12/18/65</i> 19, that (we) last saw the deceased alive on <i>12/18/65</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Kermit P. Bonovich</i> | | | | 23B. DATE SIGNED
<i>12-18-65</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>KERMIT P. BONOVICH</i> | | | | 23D. ADDRESS
<i>1213 Light St. Balto. Md. 21230</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Removal</i> | | 24B. DATE
<i>12/24/65</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>St. Vincent Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Plymouth, PA.</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>DEC 20 1965</i> | | 25B. NAME OF REGISTRAR
<i>John E. Fisher</i> | |
| 25C. FUNERAL DIRECTOR
<i>McCully Funeral Home</i> | | 25D. ADDRESS
<i>237</i> | | | |

1000 ft. (approx.)
1000 ft. (approx.)
1000 ft. (approx.)
1000 ft. (approx.)
1000 ft. (approx.)

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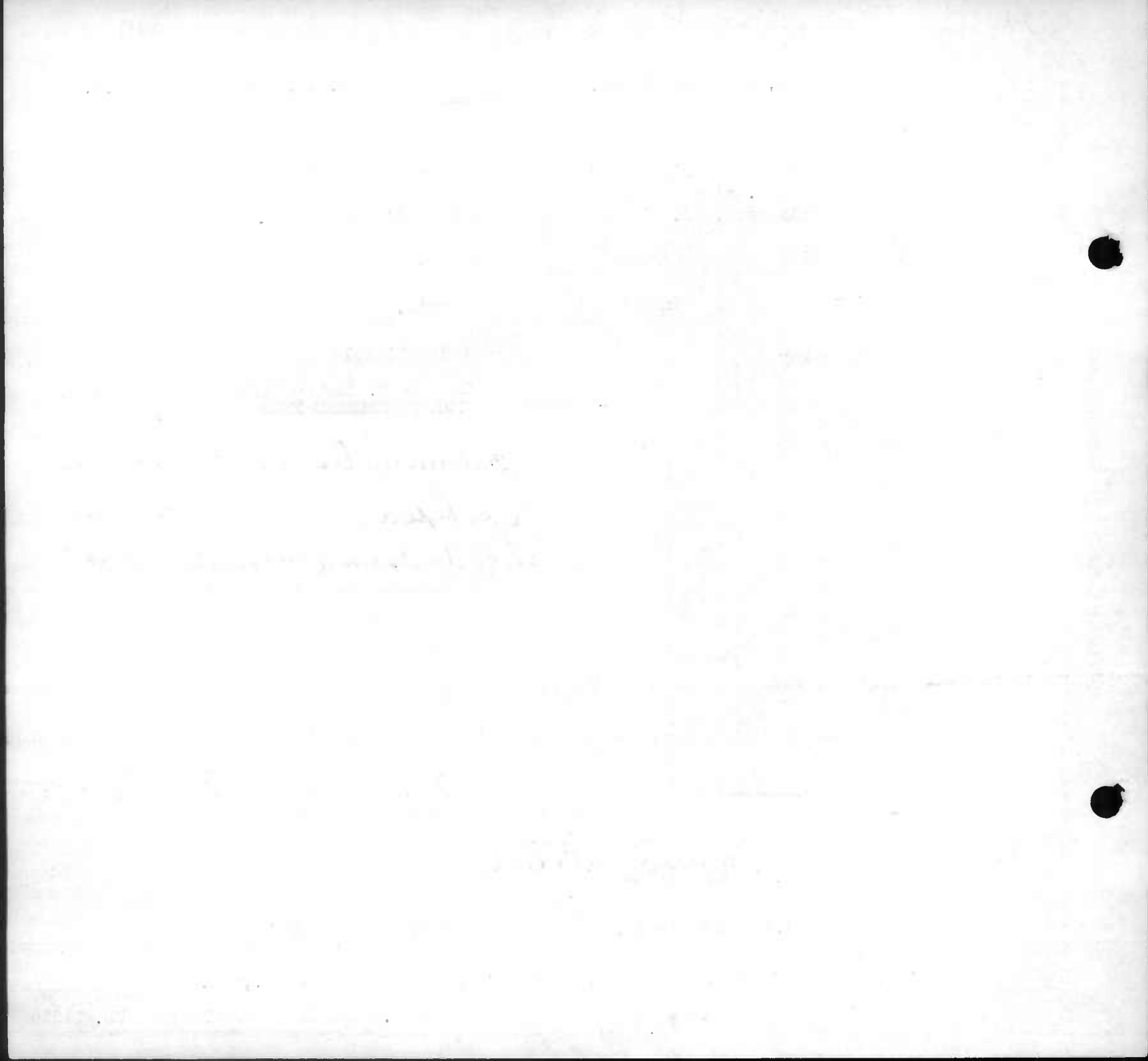
1000 ft. (approx.)

1000 ft. (approx.)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 12940 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 12940 | |
|--|--|---|--|--|--|--|--|
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print)
BEMKEY, John Joseph Sr. | | | | Dec. 16, 1965 7 a.m. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Jenkins Memorial Hospital
1000 S. Caton Avenue
Baltimore, Md. 21229 | | (If not in hospital or institution, give street address or location) | | A. STATE
Maryland | | B. COUNTY
25-52 | |
| 5. SEX
Male | | 6. RACE
White | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | | 8. DATE OF BIRTH
May 16, 1900 | |
| 9. AGE (In years last birthday)
65 | | 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machinist | | 10B. KIND OF BUSINESS OR INDUSTRY
Industrial | | 11. BIRTHPLACE (State or foreign country)
Denzig, Germany | |
| 12. CITIZEN OF WHAT COUNTRY?
U S A | | 13. FATHER'S NAME
Adolph Bemkey | | 14. MOTHER'S MAIDEN NAME
Helen Nickels | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No No | |
| 16. SOCIAL SECURITY NO.
215-03-6003 | | 17. INFORMANT
Camilla M. Bemkey | | ADDRESS
1718 Wilmington Ave.
Medical Records Room | | 18. 1939 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | |
| 19A. DATE OF OPERATION
1939 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from Dec 3 19 65 to Dec 16 19 65 , that (H) (we) last saw the deceased alive on Dec 16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE
J. Raymond Gladue
M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | |
| 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type)
J. Raymond Gladue | | 23D. ADDRESS
Jenkins Memorial Hospital
1000 Caton Ave 21229 | | 24. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | |
| 24B. DATE
12/18/65 | | 24C. NAME OF CEMETERY or CREMATORY
MEADOWRIDGE CEMETERY | | 24D. LOCATION (City, town, or county) (State)
HOWARD CO., MD. | | 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | |
| 25B. NAME OF REGISTRAR
Robert E. Gladue | | 25C. FUNERAL DIRECTOR
HOWARD H. HUBBARD | | ADDRESS
4107 WILKENS AVE. 21229 | | VS 150-REV. 1/1/65 | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|---------|--|--|------------------------------------|---|---|---|---------------------------------|--|--|
| 65 12941 | | | | | 65 12941 | | | | | |
| BIRTH NO. | | | | | REGISTERED NO. | | | | | |
| M.E. CASE NO. | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| Robert Eugene Quinnette | | | | | Dec. 14, 1965 1: 25 A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | | | A. STATE B. COUNTY | | | | | |
| US Public Health Service Hospital
Wyman Pk. Drive & 31st Street | | | | | NJ | | | | | |
| | | | | | C. CITY OR TOWN
(If outside city limits, write RURAL and give township) | | | | | |
| | | | | | Pennsville | | | | | |
| | | | | | D. STREET ADDRESS
(If rural, give location) | | | | | |
| | | | | | 33 Maple Avenue | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | 9. AGE (In years
last birthday) | 10. Under 1 Yr.
Months Days | | 11. Under 24 Hrs.
Hours Min. | | |
| M | W | Married | | 5/31/30 | 35 | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Foreman | | | Glass factory | | Pa. | | | USA | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| Franklin Quinnette | | | | | Margaret Westfall | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| Yes USA 1948-1949 | | | 157-22-9076 | | Records- US PHS Hospital, Balto, Md. | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | CAUSE OF DEATH | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | (A) DUE TO | | | | | |
| Pulmonary edema | | | | | & gastrointestinal hemorrhage | | | | | |
| ANTECEDENT CAUSES | | | | | (B) DUE TO | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | Myelogenous leukemia | | | | | |
| | | | | | (C) DUE TO | | | | | |
| | | | | | | | | | | |
| II | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | Hours | | | | | |
| | | | | | Days | | | | | |
| | | | | | Months | | | | | |
| | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | |
| | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED | | | 21F. HOW DID INJURY OCCUR? | | | | |
| | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from May 17, 1965 to Dec. 14, 1965, that (I) (we) last saw the deceased alive on Dec. 14, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE | | | | | 23B. DATE SIGNED | | | | | |
| James M. Weaver | | | | | 12/15/65 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS | | | | | |
| James M. Weaver, Medical Director M.D. | | | | | US PHS Hospital, Balto, Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | | 24D. LOCATION (City, town, or county) (State) | | | |
| BURIAL | | 12/17, 1965 | | LAWNSIDE CEMETERY | | | WOODSTOWN, NEW JERSEY | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. | | | 25B. NAME OF REGISTRAR | | | 25C. FUNERAL DIRECTOR ADDRESS | | | | |
| DEC 20 1965 | | | Robert E. Weaver | | | HUBBARD FUNERAL HOME 4107 WILKENS AVE. 21229 | | | | |

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BIRTH NO. 65 12942 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12942

M.E. CASE NO.

| | | | | | |
|---|------------------|---|--|--------------------------------------|---|
| 1. NAME OF DECEASED
(Type or Print) ANDREA LYNN HEISTERMAN | | | 2. DATE AND HOUR PRONOUNCED DEAD
December 15, 1965 6:30 P M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
38 University Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Pasadena
D. STREET ADDRESS (If rural, give location)
RT. 5, Box 386, A.A. | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
CHILD | 8. DATE OF BIRTH
Jan. 17, 1958 | 9. AGE (In years last birthday)
7 | If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CHILD | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
CARROLL HEISTERMAN | | | 14. MOTHER'S MAIDEN NAME
DORIS EILEEN FARMER | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
----- | 17. INFORMANT
ADDRESS PASADENA, MD.
MR. CARROLL HEISTERMAN, RT. 5, BOX 386 A.A. | | |

| | | | |
|-----------------------|--|--|----------------------------------|
| MEDICAL CERTIFICATION | 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Multiple Traumatic Injuries.
(A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH |
| | ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO | | |
| | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C) DUE TO | | |

| | | | | | | | |
|---|--|--|--|--|---|--|--|
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Street | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
10th Ave. & B Street, Chelsea Beach | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
12 15 '65 A | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
Pedestrian struck by auto. | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ACTUAL SIGNATURE <i>Charles S. Petty</i> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
EXAMINER'S NAME (Type) Charles S. Petty, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 12/16/65 | | | | | | | |

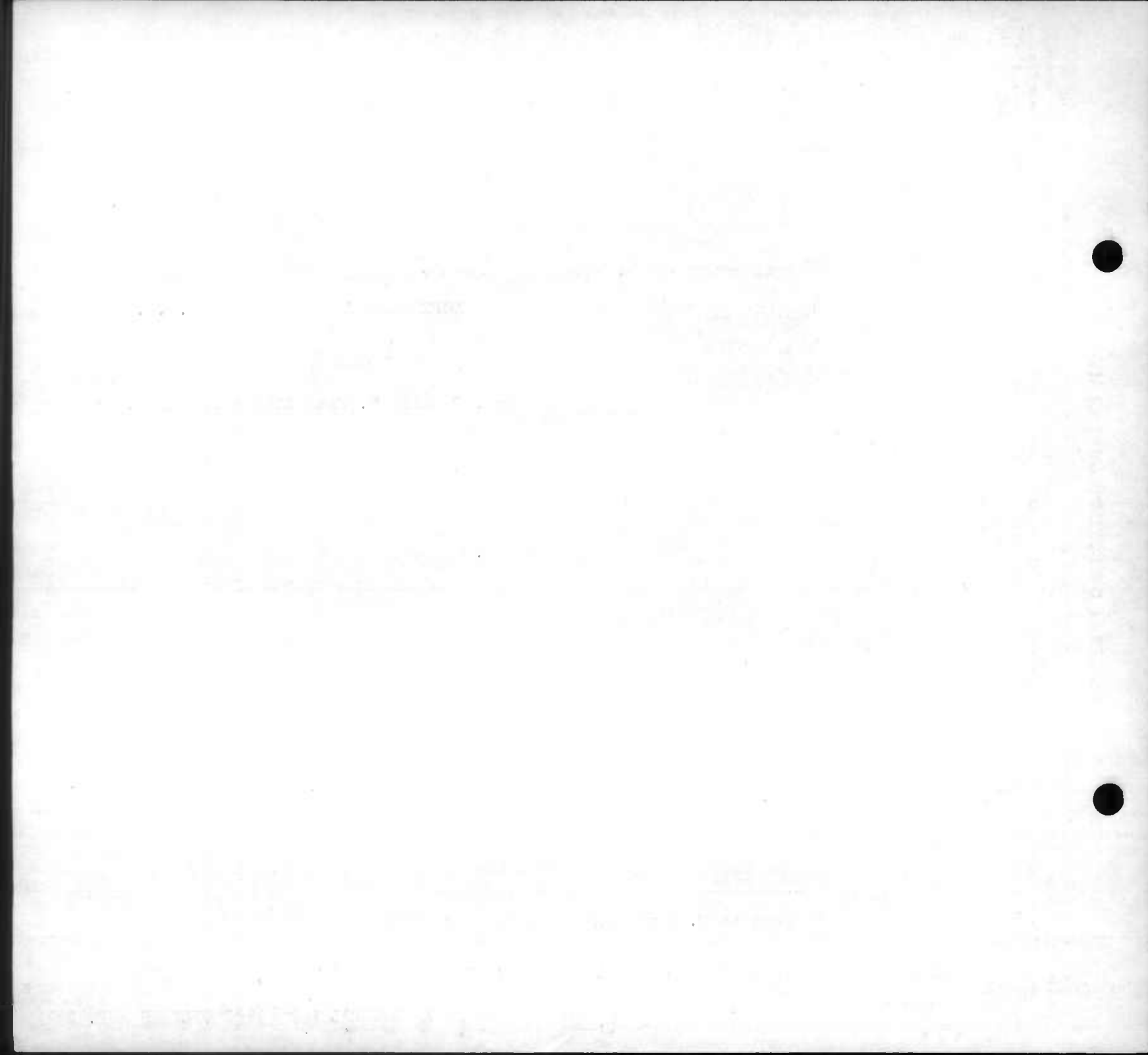
| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 23A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 23B. DATE
12/18/65 | | 23C. NAME of CEMETERY or CREMATORY
LOUDON PARK CEMETERY | | 23D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | |
| 24A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 24B. NAME OF REGISTRAR
P. R. E. 2, J. R. M. A. | | 24C. FUNERAL DIRECTOR ADDRESS
HUBBARD FUNERAL HOME, 4107 WILKENS AVE. #29 | | | |

WALLS OF GEORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---|--|---|---|--|
| BIRTH NO.
65 12943 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 65 12943 | |
| 1. NAME OF DECEASED
(Type or Print)
Kathryn H. Bruhy | | | 2. DATE AND HOUR OF DEATH
12-15-65 1445 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
University of Maryland Hosp | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Md
B. COUNTY 28-04
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
5124 Greenwich Ave # 29 | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Separated | 8. DATE OF BIRTH
1-4-05 | 9. AGE (In years last birthday)
60 | 10. Under 1 Yr. Months: Days: It Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Practical Nurse | | 10B. KIND OF BUSINESS OR INDUSTRY
Nurse | 11. BIRTHPLACE (State or foreign country)
NORTH DAKOTA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Hartuis Halvorsen | | | 14. MOTHER'S MAIDEN NAME
Thora Lund | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT
Mrs. Gunhild H. King 2240 Howard Ave. San Carlos California | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
DISEASE OR CONDITION CAUSING IT.
I
199.2 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
Aspiration of Vomitus
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
19A. DATE OF OPERATION
April 65
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
for Diagnosis
20A. AUTOPSY? (Yes or No)
NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | INTERVAL BETWEEN ONSET AND DEATH
7 months | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-26-1965 to 12-15-1965, that (I) (we) lost saw the deceased alive on 12-15-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Douglas W. Davidson M.D. | | | 23B. DATE SIGNED
12-15-65 | | 23C. PHYSICIAN'S NAME (Type)
Douglas W. Davidson M.D. |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
12/17/65 | 24C. NAME OF CEMETERY or CREMATORY
LOUDON PARK CEMETERY | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS
HUBBARD FUNERAL HOME 4407 WILKENS AVE. 21229 | |



1

65 12944

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12944

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HILDA MARIE FURR

2. DATE AND HOUR PRONOUNCED DEAD

December 15, 1965 7:10 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5250 Reisterstown Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

JAN. 11, 1921

9. AGE (in years
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

F. PETE HELFELY

14. MOTHER'S MAIDEN NAME

M. JANIE VERMILLION

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

LOUIE FURR, XXXXX 5250 REISTERSTOWN ROAD

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Bronchopneumonia.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Fatty Liver.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/16/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

12/19/65

23C. NAME OF CEMETERY or CREMATORY

BENNETTE CHAPEL

23D. LOCATION

(City, town, or county)

(State)

WARREN COUNTY, VIRGINIA

24A. DATE REC'D BY HEALTH DEPT.

DEC 20 1965

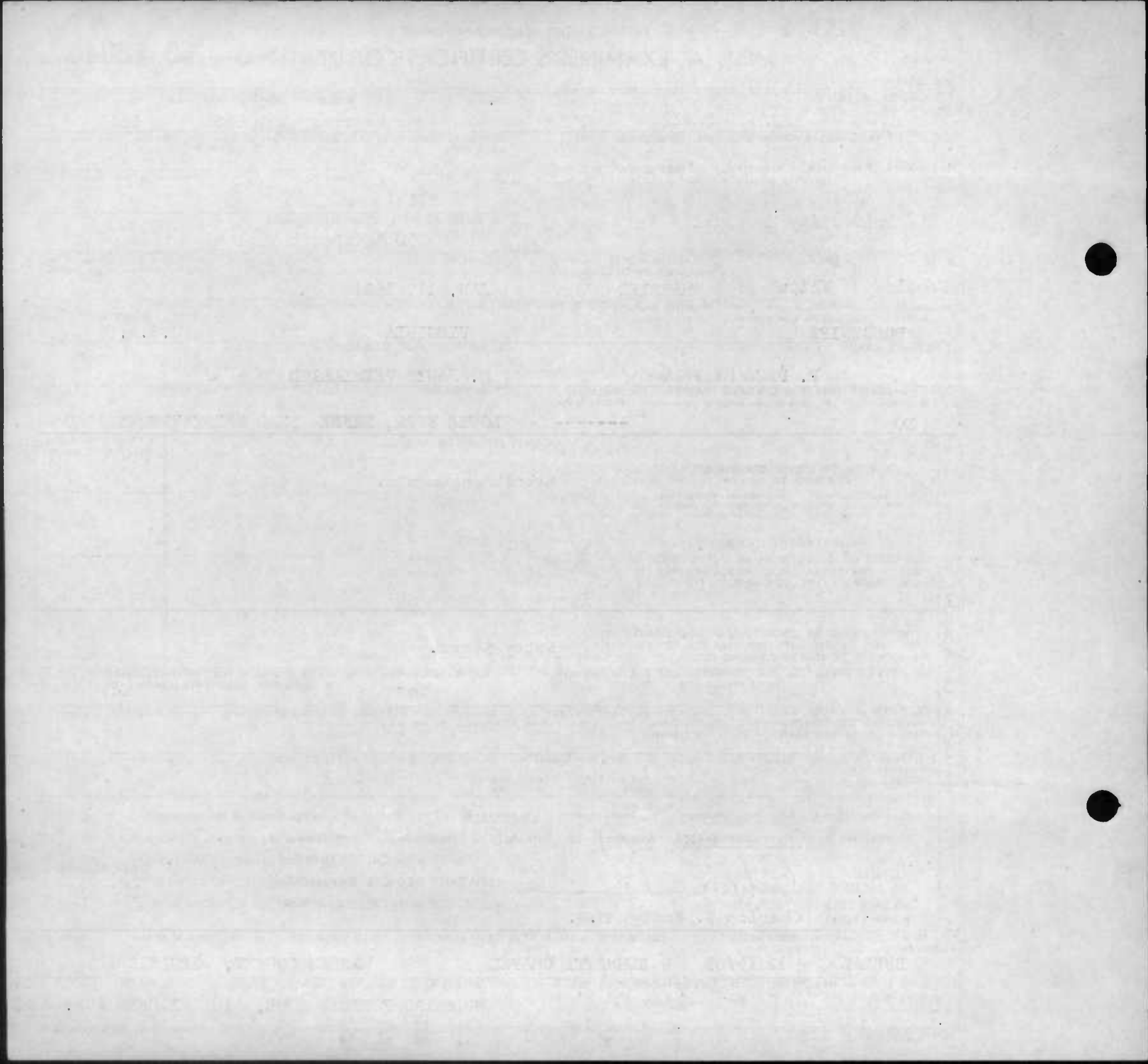
24B. NAME OF REGISTRAR

Robert E. Petty, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

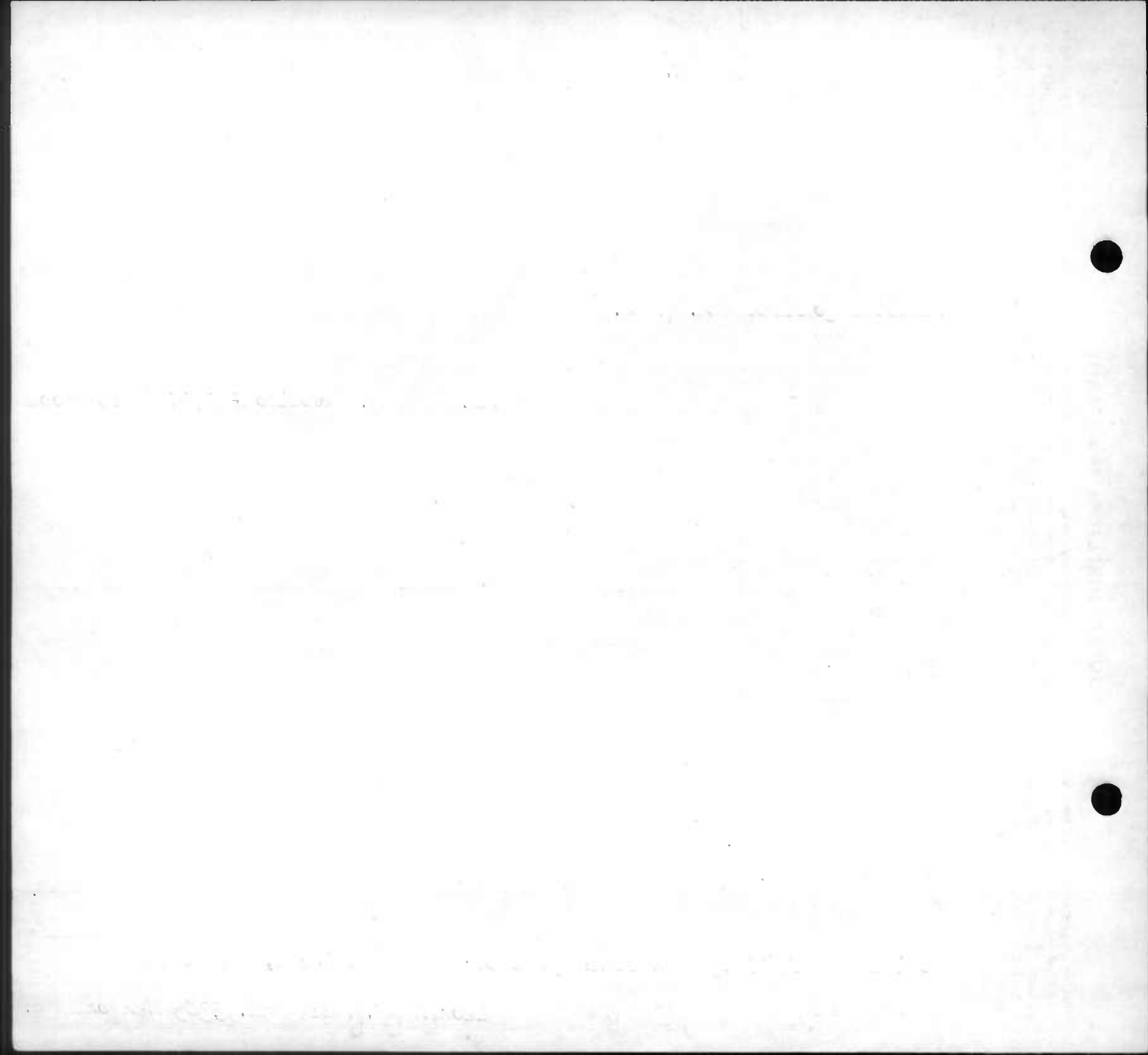
HUBBARD FUNERAL HOME, 4107 WILKENS AVE. # 29



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

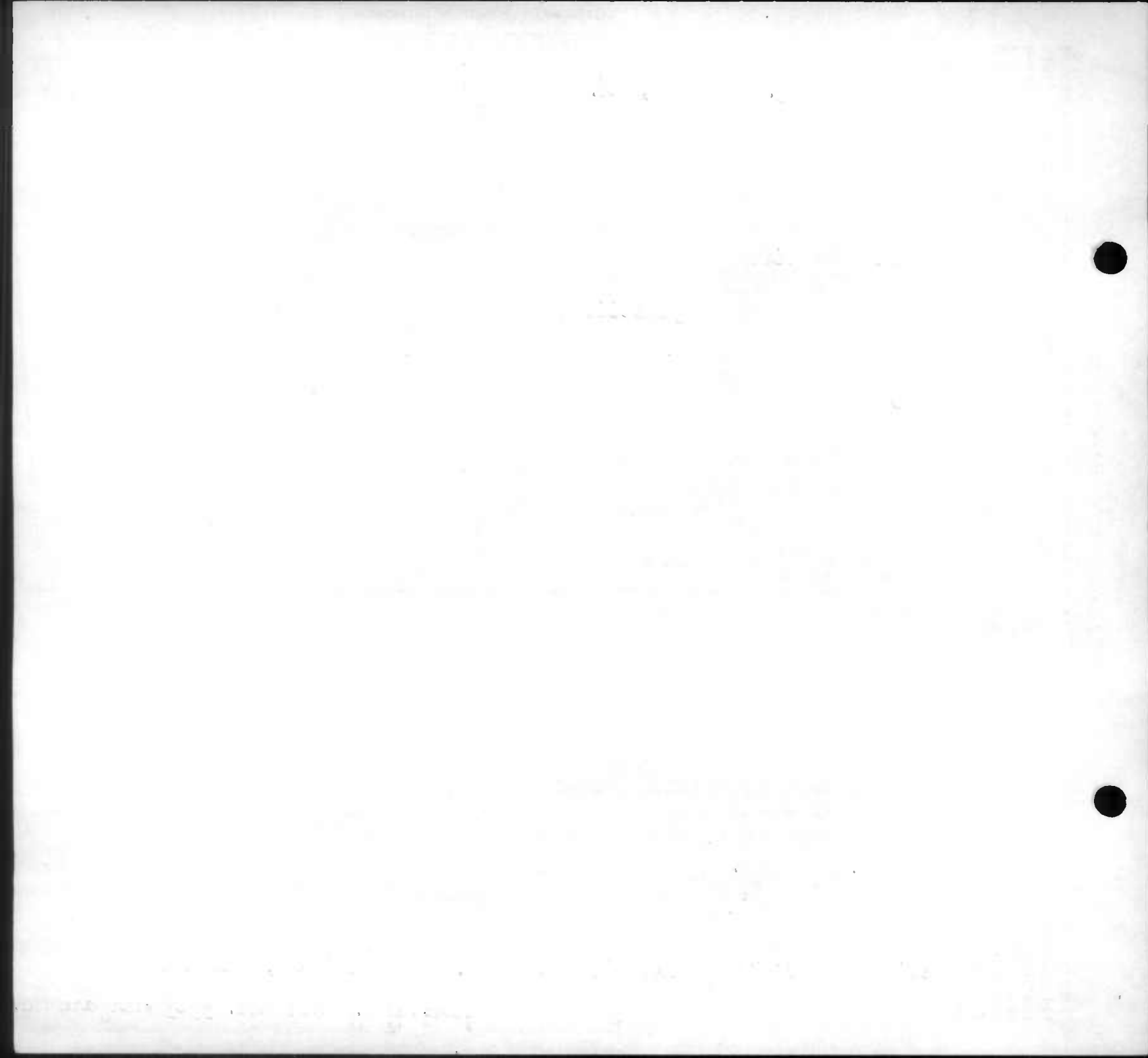
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | |
|--|--|-------------------------|--|--|---|-------------------------------------|--|--|--|---|--|--|--|--|---|---|--|--|--|
| 65 12945 | | | | | Certificate of Death | | | | | Registered No. 65 12945 | | | | | | | | | |
| BIRTH NO. | | | | | | | | | | M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Mr. Wilbur H. Morrison</i> | | | | | | | | | | 2. DATE AND HOUR OF DEATH
<i>Dec. 19, 1965 11:05 AM</i> | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>2707</i> | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>Maryland General Hospital</i> | | | | | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>BALTIMORE</i> | | | | | | | | | |
| (If not in hospital or institution, give street address or location) | | | | | | | | | | D. STREET ADDRESS (If rural, give location)
<i>2901 Bauernwood Ave</i> | | | | | | | | | |
| 5. SEX
<i>Male</i> | | 6. RACE
<i>White</i> | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Married</i> | | 8. DATE OF BIRTH
<i>10/29/19</i> | | 9. AGE (In years last birthday)
<i>46</i> | | If Under 1 Yr. Months: Days: Hours: Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Collect Mgr. (Ret.)</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | |
| 13. FATHER'S NAME
<i>William Morrison</i> | | | | | | | | | | 14. MOTHER'S MAIDEN NAME
<i>Irene Schissler</i> | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>Yes WW2</i> | | | | | | | | | | 16. SOCIAL SECURITY NO.
<i>212 69 3748</i> | | | | | | | | | |
| 17. INFORMANT
<i>Mrs. Reba R. Morrison</i> | | | | | | | | | | ADDRESS
<i>2901 Bauernwood</i> | | | | | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>420.1 I</i> | | | | | | | | | | CAUSE OF DEATH
(A) DUE TO
<i>Acute Myocardial Infarct</i>
(B) DUE TO
<i>Coronary Atherosclerosis</i>
(C) _____ | | | | | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| II | | | | | | | | | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No)
<i>NO</i> | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>11:36</i> 19 <i>65</i> to <i>12:19</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>12-19</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE
<i>[Signature]</i> | | | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED
<i>12-19-65</i> | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | | | | | 23D. ADDRESS
M.D. | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | | | 24B. DATE
<i>12/22/65</i> | | | | | 24C. NAME OF CEMETERY or CREMATORY
<i>Moreland Cemetery</i> | | | | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Maryland</i> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>DEC 20 1965</i> | | | | | 25B. NAME OF REGISTRAR
<i>[Signature]</i> | | | | | 25C. FUNERAL DIRECTOR
<i>Leonard J. Ruck Inc.</i> | | | | | | | | | |
| | | | | | | | | | | ADDRESS
<i>5305 Harford Rd.</i> | | | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|---|------------------------------|
| 65 12946 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 12946 | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | |
| | | | | JOHN E. PARKS, Sr. | |
| 2. DATE AND HOUR OF DEATH | | 12-19-65 6 AM M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | A. STATE
B. COUNTY | | | |
| CHURCH HOME + HOSPITAL | | MARYLAND | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 65 32 ROSEMONT AVE | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| Male | White | MARRIED | 4-26-88 | 77 | USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| RETIRED - I.B.E.W. Electrical | | | | MARYLAND | |
| 12. FATHER'S NAME | | 13. MOTHER'S MAIDEN NAME | | 14. CITIZEN OF WHAT COUNTRY? | |
| CHARLES PARK | | MARY MCGINNIS | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 218 012157 CHART | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 5-27-21 | | NEOPLASM OR INFILTRATE | | | |
| ANTECEDENT CAUSES | | IN THE LEFT LUNG | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 0 | | NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | | | |
| | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| MARIANO A. TOLENTINO | | | | 12-19-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| MARIANO A. TOLENTINO | | CHURCH & HOME + HOSP. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) | | |
| Burial | 12/22/65 | Lorraine Park Cem. | Baltimore, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| DEC 20 1965 | | Leonard J. Ruck Inc. | | 5305 Harford Rd. | |



F500

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12947 | |
|--|---------------|--|----------------------------|---|--|
| BIRTH NO. 65 12947 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) Fink, Margaret Mary | | 2. DATE AND HOUR OF DEATH 12-18-65 6:20 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | A. STATE Maryland B. COUNTY 9-07 | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | D. STREET ADDRESS (If rural, give location) 1603 Gorsuch Avenue 21218 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 7-30-1918 | 9. AGE (In years last birthday) 47 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Patrick Stafford | | 14. MOTHER'S MAIDEN NAME Mary Hall | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. 273206347 | | 17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224 | | | |
| 18. 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Respiratory arrest (B) Metastatic Breast CA (C) | | INTERVAL BETWEEN ONSET AND DEATH 4 min 5 year | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-16-65 to 12-18-65 that (I) (we) last saw the deceased alive on 12-18-65 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Brian Bouton | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 12-18-65 | |
| 23C. PHYSICIAN'S NAME (Type) BRIAN B. BOUTON | | 23D. ADDRESS BCH 4940 Eastern Avenue Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/23/65 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem. | |
| 24D. LOCATION Baltimore, Maryland | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 20 1965 | | 25B. NAME OF REGISTRAR Robert E. Jones, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. 5305 Harford Rd. | |

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BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LAURA WALKER

2. DATE AND HOUR PRONOUNCED DEAD

12/18/65 1:40 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3902 Eierman Ave.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

June 22, 1965

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

6

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Ronald H. Walker

14. MOTHER'S MAIDEN NAME

Geraldine Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

Mr. Ronald H. Walker-3902 Eierman Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)Interstitial pneumonitis
(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/19/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/21/65

23C. NAME OF CEMETERY or CREMATORY

St. Stanislaus Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

DEC 20 1965

Robert E. J. J. J.

Leonard J. Ruck Inc. 5305 Harford Rd.

WALLEY FORGE

HAD QUANTITY

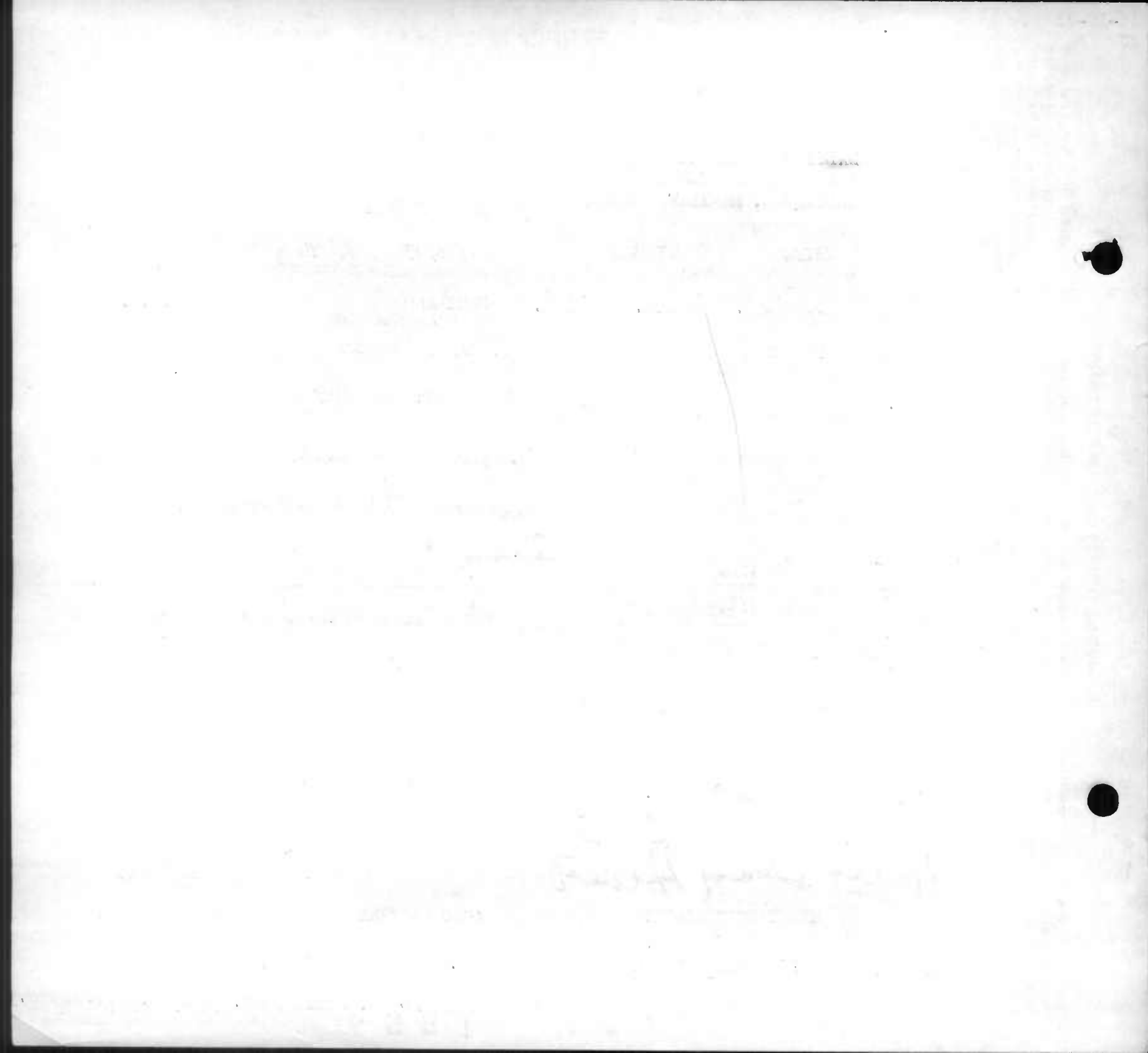
17-1

45-10-21
JJ

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | |
|--|-------------------------|---|--|
| CERTIFICATE OF DEATH | | | |
| BIRTH NO. 65 12949 | | Registered No. 65 12949 | |
| 1. NAME OF DECEASED
(Type or Print) Robert V. Clifford | | 2. DATE AND HOUR OF DEATH
12/19/65 6 93 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 26-03 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | |
| | | D. STREET ADDRESS (If rural, give location)
3443 DUDLEY AVENUE #21213 | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED | 8. DATE OF BIRTH
11/18/95 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Pipefitter Ret. | | 10B. KIND OF BUSINESS OR INDUSTRY
Penna. Rail R. | 9. AGE (In years last birthday)
70 |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Bernard Clifford | | 14. MOTHER'S MAIDEN NAME
Hannah Norton | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Unk. | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
RECORDS: BCH 4940 EASTERN AVENUE #21224 | | ADDRESS | |
| 18. 609X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Pneumonia
CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) Severe
INTERVAL BETWEEN ONSET AND DEATH
3 wks | | | |
| 19. DATE OF OPERATION
0 mo | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Severe Parkinsons Dis | |
| 20A. AUTOPSY? (Yes or No)
no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<input type="checkbox"/> | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/14/63 19 65 to 12/19 19 65 , that (I) (we) last saw the deceased alive on 12/14 19 63 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Harry Dean Albert | | 23B. DATE SIGNED
12/19/65 | |
| 23C. PHYSICIAN'S NAME (Type)
HARRY DEAN ALBERT | | 23D. ADDRESS
4940 EASTERN AVENUE #21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12/23/65 | |
| 24C. NAME OF CEMETERY or CREMATORY
Holy Redeemer Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 20 1965 | | 25B. NAME OF REGISTRAR
Leonard J. Ruck Inc. | |
| 25C. FUNERAL DIRECTOR
5305 Harford Rd. | | ADDRESS | |

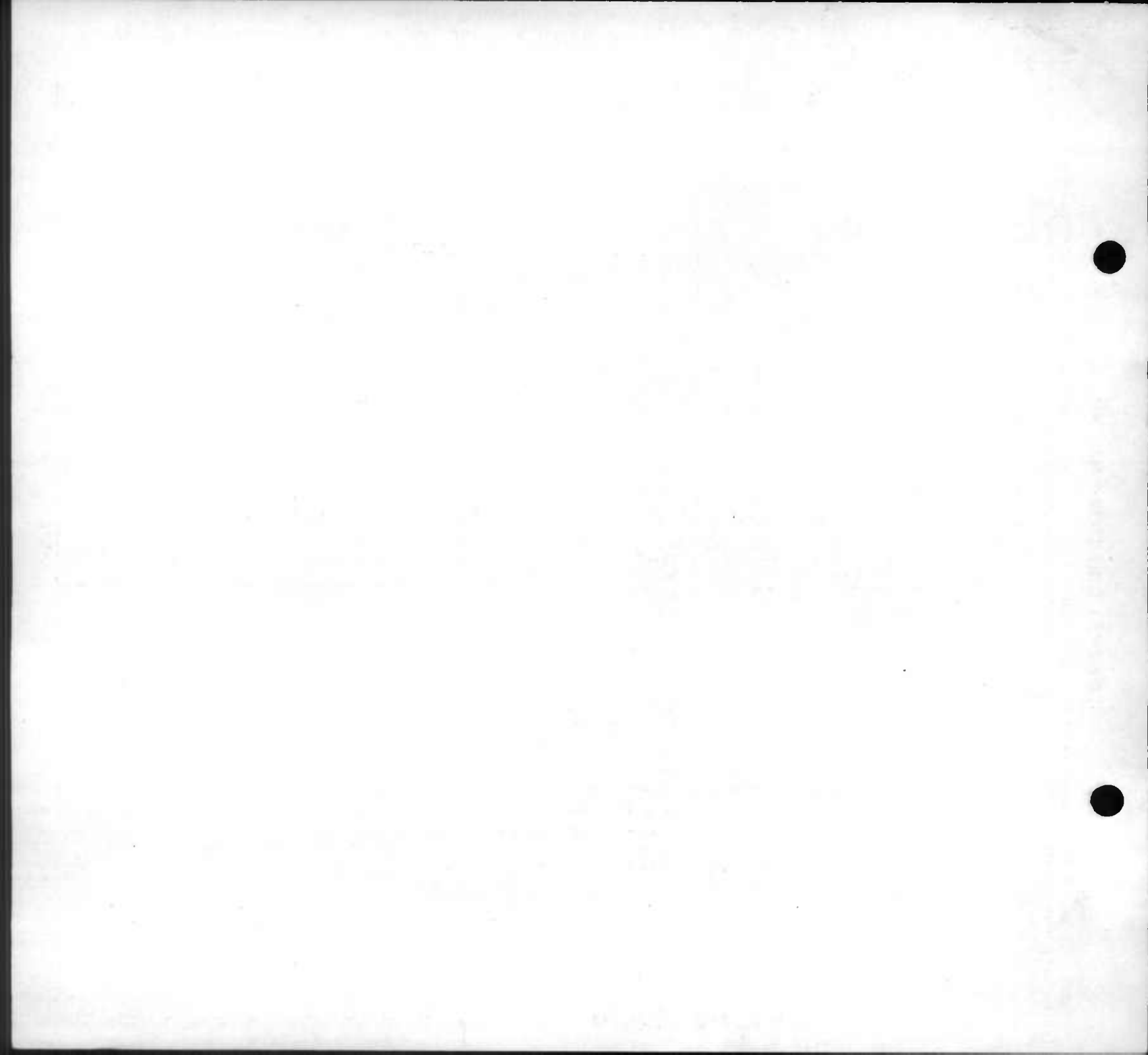


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|---------------------|--|---|
| 1. NAME OF DECEASED
(Type or Print) ANNA SWIECZKOWSKI | | 2. DATE AND HOUR OF DEATH
Dec. 20, 1965 11:20 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

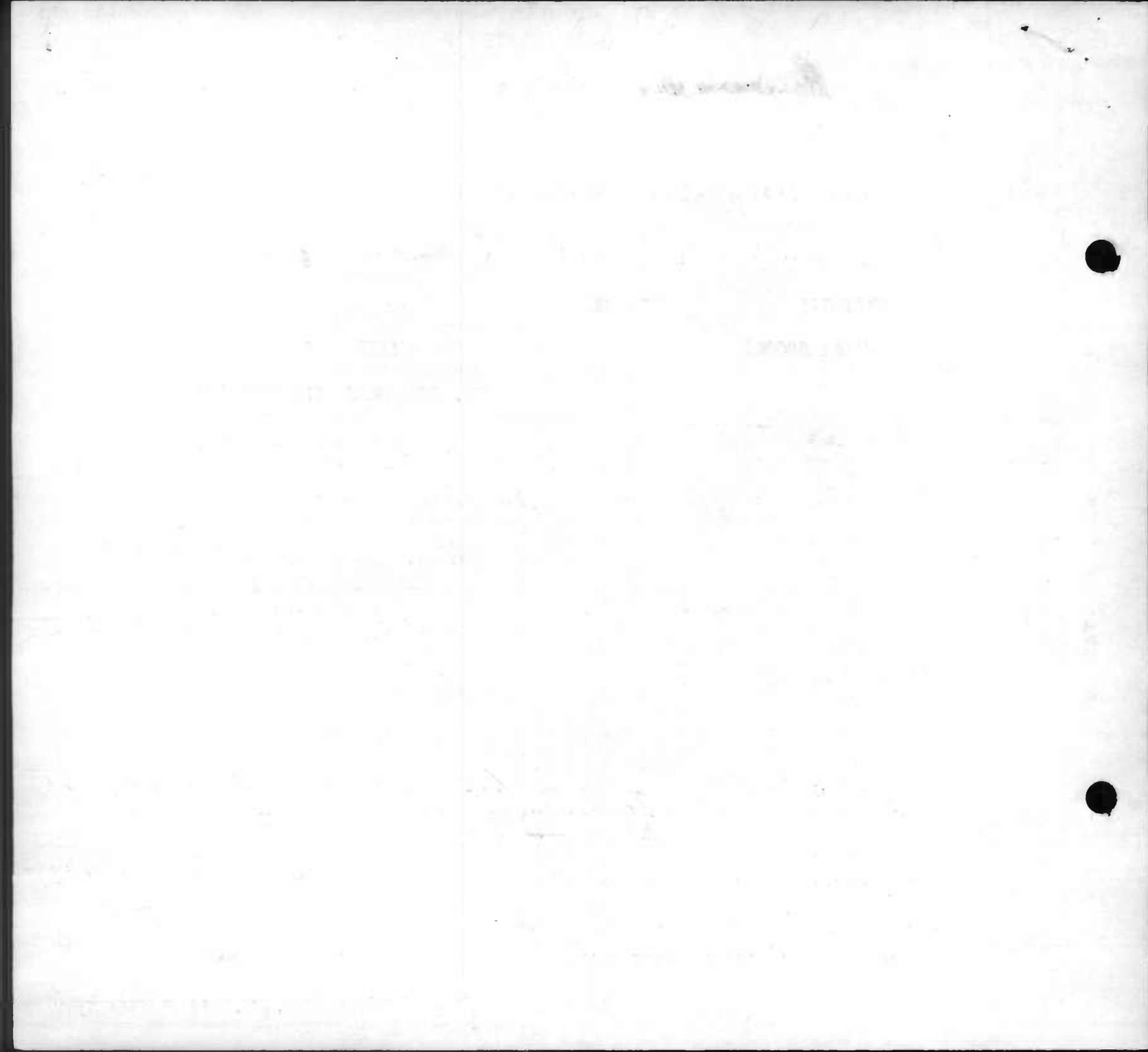
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
BALTIMORE CITY HOSPITALS | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Maryland
B. COUNTY 26-36
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
6316 Boston Street 21224 | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
11-3-1896 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 69
If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 11. BIRTHPLACE (State or foreign country)
BALTIMORE MD | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
215-14-8384 | |
| 17. INFORMANT | | ADDRESS
Records: BCH-4940 Eastern Avenue 21224 | |
| 18. 43311
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
VENTRICULAR FIBRILLATION | | INTERVAL BETWEEN ONSET AND DEATH
40 minutes | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) ARTERIOSCLEROTIC CV DISEASE
3 YEARS | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 4 1965 to Dec. 20 1965 , that (I) (we) last saw the deceased alive on Dec. 20 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Barry Wayne Uhr | | 23B. DATE SIGNED
Dec. 20, 1965 | |
| 23C. PHYSICIAN'S NAME (Type)
BARRY WAYNE UHR | | 23D. ADDRESS
M.D. 4940 Eastern Avenue, Baltimore, Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
12/24/65 | |
| 24C. NAME OF CEMETERY or CREMATORY
HOLY ROSARY CEMETERY | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE CO MD | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 21 1965 | | 25B. NAME OF REGISTRAR
John M. Weber & Sons Inc. | |
| 25C. FUNERAL DIRECTOR'S ADDRESS
401 S. CHESTER ST | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. | |
|---|--|---|--|---|--|--|--|---|--|--|--|
| BIRTH NO. 65 12951 | | | | | | | | | | 65 12951 | |
| M.E. CASE NO. 65 12951 | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) (ZAMANSKY) SNYDER, Bessie | | | | | | | | | | 2. DATE AND HOUR OF DEATH December 15 1965 8:45 P.M. | |
| 3. PLACE OF DEATH BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital of Baltimore | | | | | | | | | | A. STATE Md. B. COUNTY Balto | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) 810 Hopewood Rd. #8 | | | | | | | | | | D. STREET ADDRESS (If rural, give location) 5300 | |
| 5. SEX Female | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | | 8. DATE OF BIRTH 1/1/1910 | | 9. AGE (In years last birthday) 55 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | |
| 11. BIRTHPLACE (State or foreign country) Russia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME SAMUEL BROOKS | | 14. MOTHER'S MAIDEN NAME MOLLIE ? | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT MRS. EDNA HESS | | ADDRESS 810 HOPEWOOD ROAD | | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH Probable gram. negative sepsis | | INTERVAL BETWEEN ONSET AND DEATH ~ 12 hrs | | | |
| 19. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (this hospital) attended the deceased from December 12, 1965 to December 15, 1965, that (we) lost saw the deceased alive on December 15, 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Benjamin R. Chipman, M.D. | | 23B. DATE SIGNED Dec. 15, 1965 | | 23C. PHYSICIAN'S NAME (Type) B.R. Chipman, M.D. | | 23D. ADDRESS 9 Sinai Hospital | | 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 12/17/65 | |
| 24C. NAME OF CEMETERY OR CREMATORY AITZ CHAIM | | 24D. LOCATION BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. DEC 21 1965 | | 25B. NAME OF REGISTRAR SOL LEVINSON & BROS. INC. | | 25C. FUNERAL DIRECTOR ADDRESS 6010 REISTERSTOWN RD | | | |

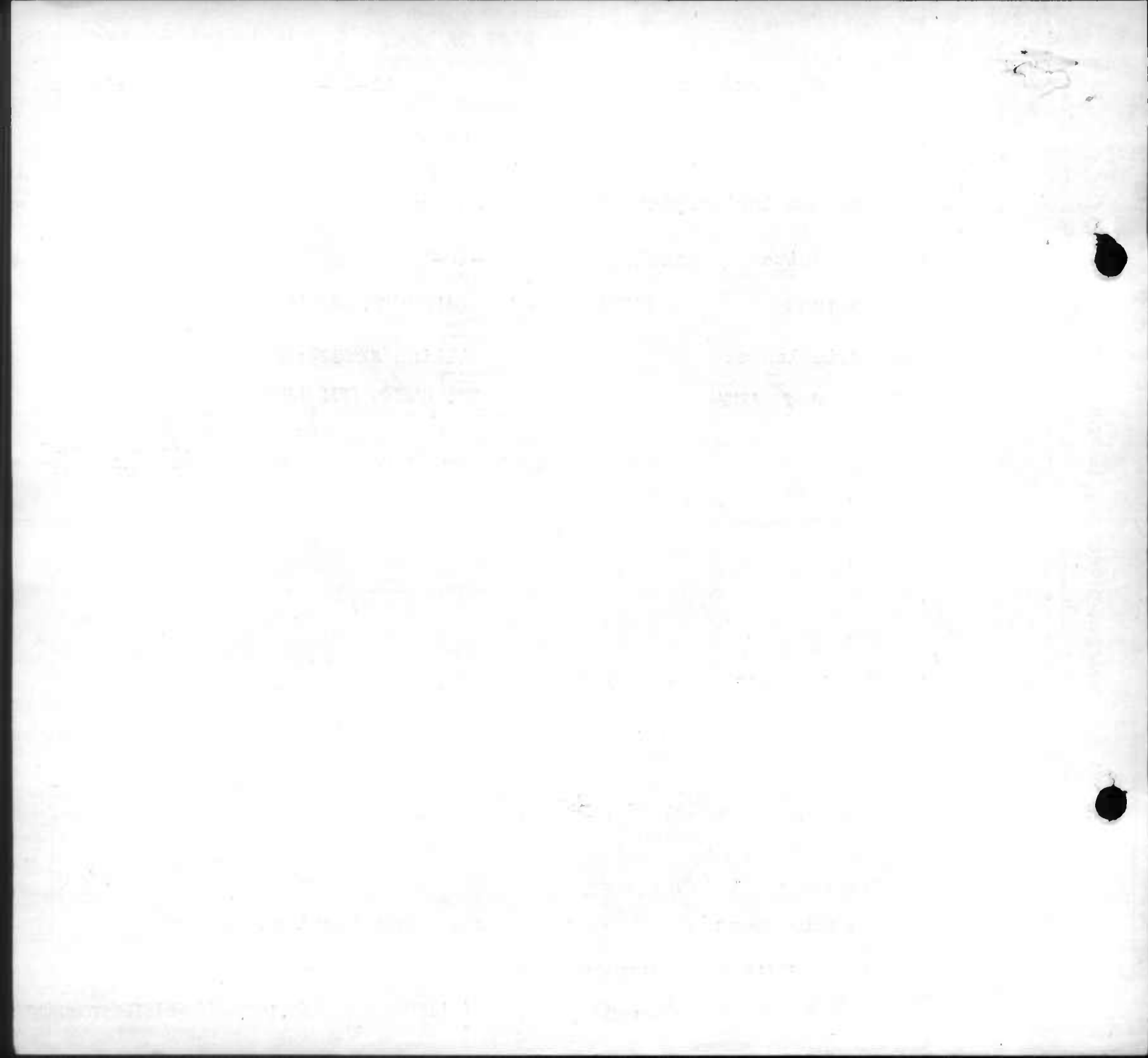


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|---|--|---|
| BIRTH NO.
65 12952 | | CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 65 12952 | |
| 1. NAME OF DECEASED
(Type or Print)
Ralph Friedlander | | | 2. DATE AND HOUR OF DEATH
12-15-65 2:25 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
The Johns Hopkins Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
Grasty Road | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
6-10-18 | 9. AGE (In years last birthday)
47 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MANUFACTURER | | 10B. KIND OF BUSINESS OR INDUSTRY
UNIFORMS | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Harry Friedlander | | | 14. MOTHER'S MAIDEN NAME
Lillian Freedman | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
YES WW 2 ARMY | | 16. SOCIAL SECURITY NO. | 17. INFORMANT
MRS. MARION FRIEDLANDER
ADDRESS
GRASTY RD | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
43-2X1
CAUSE OF DEATH
Left Carotid aneurysm.
INTERVAL BETWEEN ONSET AND DEATH
Nov. 23-1965
Dec. 15-1965 | | | (A) DUE TO
(B) DUE TO
(C) DUE TO | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 21A. DATE OF OPERATION
Dec-14-1965 | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Left Carotid aneurysm | | 22A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 3 - 1965 to Dec. 15 - 1965 , that (I) (we) last saw the deceased alive on Dec. 15 - 2:35 pm , 19, 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Sumio Uematsu | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
12-15-1965 |
| 23C. PHYSICIAN'S NAME (Type)
Sumio Uematsu | | | 23D. ADDRESS
M.D. The Johns Hopkins Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
12/16/65 | | 24C. NAME OF CEMETERY or CREMATORY
BALTIMORE HEBREW | |
| 24D. LOCATION (City, town, or county) (State)
REISTERSTOWN, MARYLAND | | 25A. DATE RECD. BY HEALTH DEPT.
DEC 21 1965 | | | |
| 25B. NAME OF REGISTRAR
Robert E. ... | | 25C. FUNERAL DIRECTOR
6010 REISTERSTOWN RD | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. | | 65 12953 | | CERTIFICATE OF DEATH | | Registered No. 65 12953 | |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) | | | | IDA LIBOWITZ | | | | 2. DATE AND HOUR OF DEATH
DECEMBER 17, 1965 11:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
2315 KEN OAK ROAD | | | | A. STATE
MARYLAND | | | | B. COUNTY
BALTIMORE | | | |
| 5. SEX
FEMALE | | | | 6. RACE
WHITE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | | 8. DATE OF BIRTH
11/4/1911 | | 9. AGE (In years, lost birthday)
54 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | | | 10B. KIND OF BUSINESS OR INDUSTRY
AT HOME | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MARYLAND | | | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
HARRY ROSEN | | | | 14. MOTHER'S MAIDEN NAME
REBECCA ? | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
MR. AARON LIBOWITZ | | | | ADDRESS
2315 KEN OAK ROAD | |
| 18. 356.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) Amyotrophic lateral sclerosis
(B) DUE TO
(C) | | | | INTERVAL BETWEEN ONSET AND DEATH
8 yrs | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/29/61 19 to 12/17/65 19, that (I) (we) last saw the deceased alive on 11/21/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Joseph Shear | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED
12/17/65 | | | |
| 23C. PHYSICIAN'S NAME (Type)
DR. JOSEPH SHEAR | | | | 23D. ADDRESS
6715 PARK HEIGHTS AVENUE | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | | | 24B. DATE
12/19/65 | | 24C. NAME of CEMETERY or CREMATORY
WORKEMENS CIRCLE | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 21 1965 | | | | 25B. NAME OF REGISTRAR
P. A. E. Z... | | | | 25C. FUNERAL DIRECTOR
SQL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | | |

8. 1944

1944

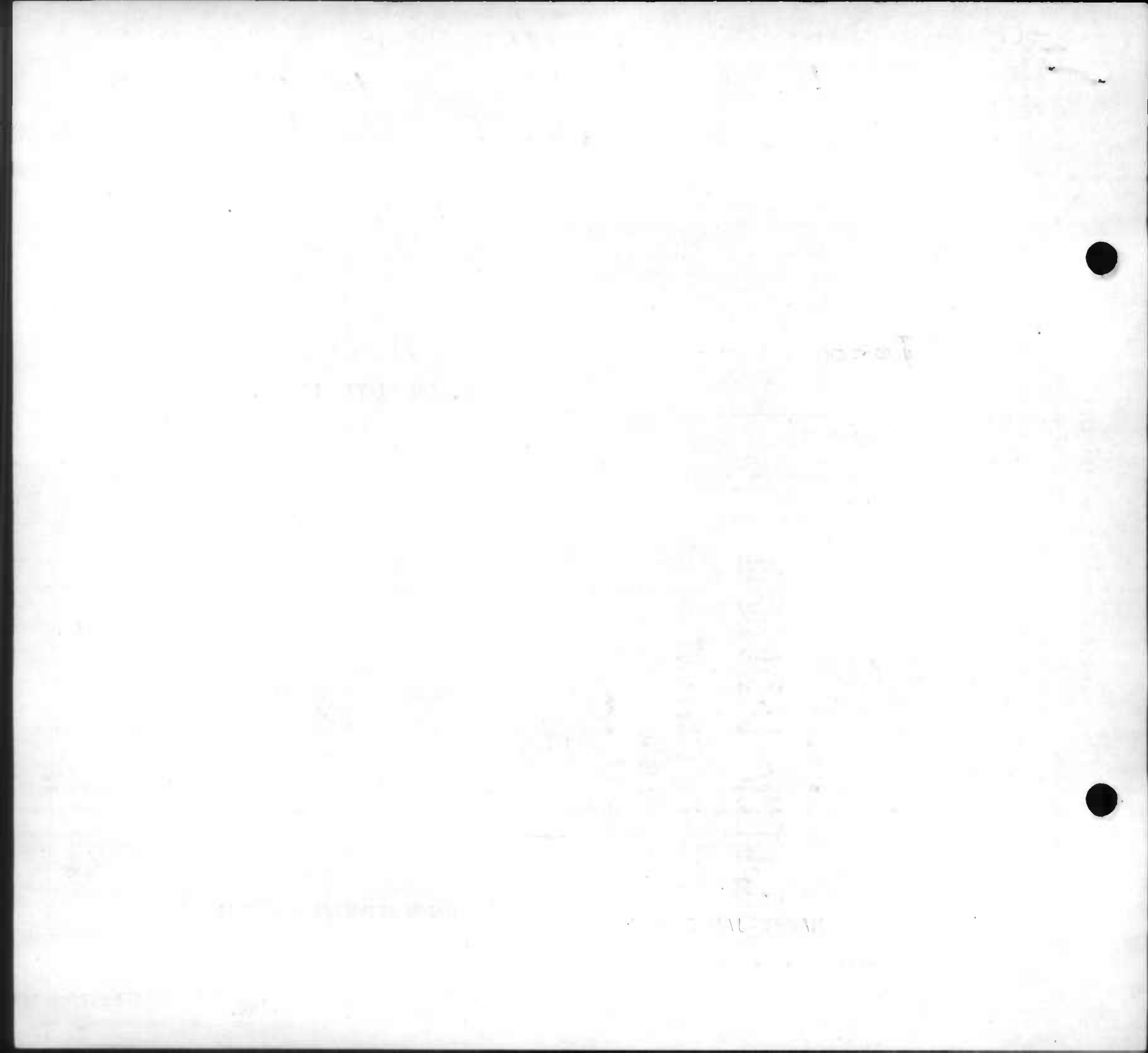
1944

1944

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | |
|---|--|----------------------|--|---|--|--------------------------------|--|---|--|---|--|---|--|--|---|--|--|--|--|
| BIRTH NO. 65 12954 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 12954 | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | 2. DATE AND HOUR OF DEATH | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) David Blatt | | | | | | | | | | 1-2/17/65 7:15 P.M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial | | | | | | | | | | A. STATE B. COUNTY Maryland 301 | | | | | | | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | | | | | | | D. STREET ADDRESS (If rural, give location) 1406 E. Lombard St. | | | | | | | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 5/1/95 | | 9. AGE (In years last birthday) 70 yrs | | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glass Glazier | | | | 10B. KIND OF BUSINESS OR INDUSTRY Self Employed Glazier | | | | 11. BIRTHPLACE (State or foreign country) Poland | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Bernard Blatt | | | | | | | | | | 14. MOTHER'S MAIDEN NAME Gittel Adelman | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT ADDRESS MRS. IDA BLATT 1406 E. LOMBARD STREET | | | | | | | | | |
| 18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | | CAUSE OF DEATH | | | | | | | | | |
| | | | | | | | | | | (A) Cerebral Thrombosis & Pulmonary 12/15/65 to 12/17/65 | | | | | | | | | |
| | | | | | | | | | | (B) DUE TO | | | | | | | | | |
| | | | | | | | | | | (C) DUE TO | | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| ANTECEDENT CAUSES | | | | | | | | | | | | | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 N/A | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A | | | | | 20A. AUTOPSY? (Yes or No) N/A | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? N/A | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) N/A | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N/A | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) N/A | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> N/A | | | | | 21F. HOW DID INJURY OCCUR? N/A | | | | | | | | | |
| 22. I certify that (this hospital) attended the deceased from 12/15/65 to 12/17/65 that (we) lost saw the deceased alive on 12/17/65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE Harry James Brown M.D. | | | | | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED 12/17/65 | | | | |
| 23C. PHYSICIAN'S NAME (Type) DR. HARRY JAMES BROWN | | | | | | | | | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | | 24B. DATE 12/19/65 | | | | | 24C. NAME OF CEMETERY or CREMATORY RUDOMER VEREIN | | | | | 24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 21 1965 | | | | | 25B. NAME OF REGISTRAR Robert E. [unclear] | | | | | 25C. FUNERAL DIRECTOR SPL LEVINSON & BROS. INC. | | | | | ADDRESS 6010 REISTERSTOWN RD | | | | |



FUNERAL DIRECTOR: IMPORTANT

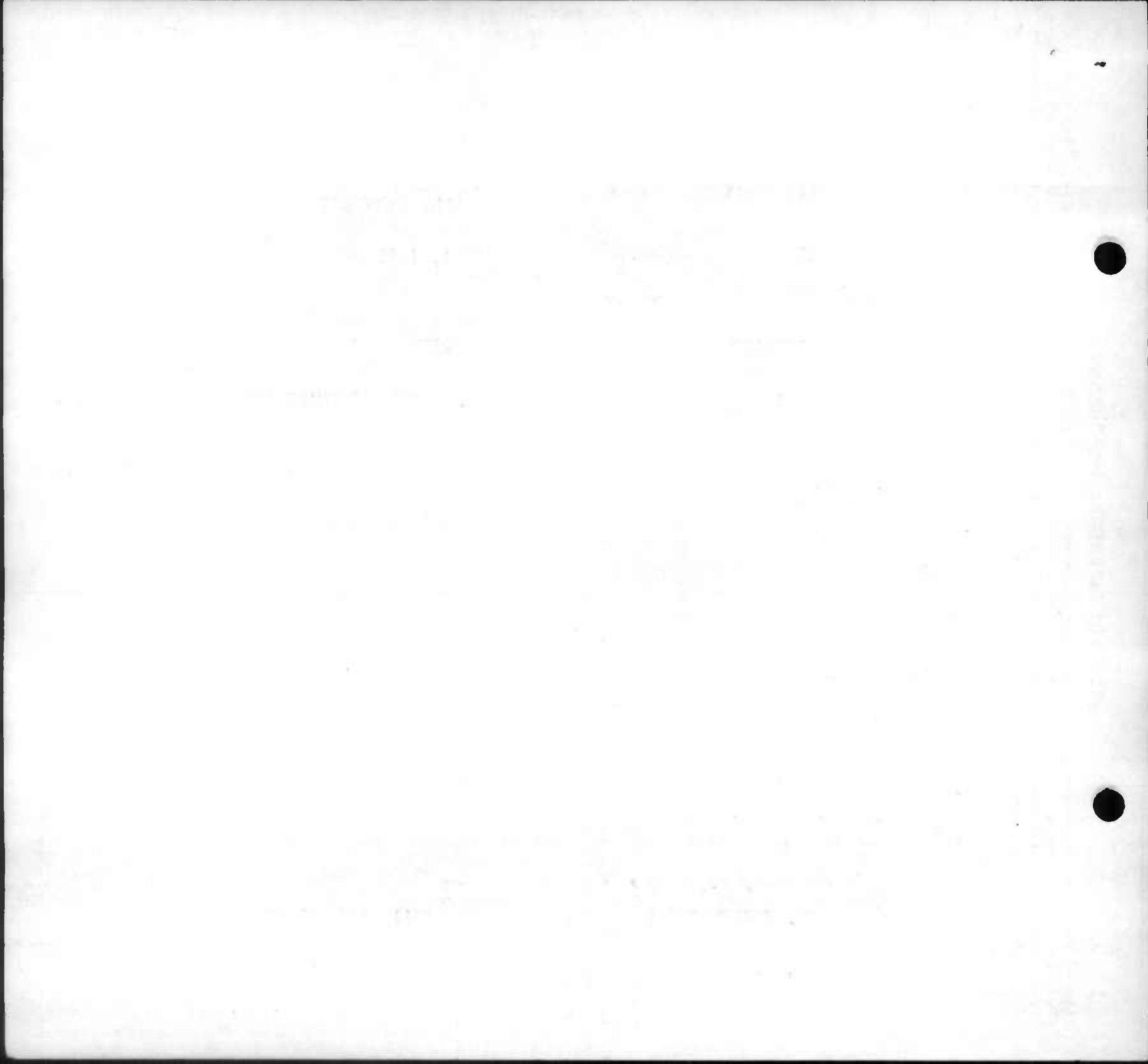
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|--|---|--|--|---|--|---|--|
| BIRTH NO. 65 12955 | | | | | CERTIFICATE OF DEATH | | | Registered No. 65 12955 | |
| 1. NAME OF DECEASED
(Type or Print) HARRY DISCHLER | | | | | 2. DATE AND HOUR OF DEATH
DECEMBER 16, 1965 10 P M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

6216 WOODCREST AVENUE | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY 27-20
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
6216 WOODCREST AVENUE | | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
APRIL, 1895 | 9. AGE (In years last birthday)
70 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | | 10B. KIND OF BUSINESS OR INDUSTRY
MERCHANT | | 11. BIRTHPLACE (State or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
MARK DISCHLER | | | | | 14. MOTHER'S MAIDEN NAME
ROSE ? | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
YES WW 1 | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
MRS. FRITZI DISCHLER 6216 WOODCREST AVENUE | | | | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH
(A) DUE TO Coronary Artery Disease
(B) DUE TO
(C) | | | INTERVAL BETWEEN ONSET AND DEATH
15 year | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1950 to Dec 16, 1965 , that (I) (we) last saw the deceased alive on Dec 16, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Dr. Joseph Gross M.D. | | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED
Dec 17/1965 | |
| 23C. PHYSICIAN'S NAME (Type)
DR. JOSEPH GROSS | | | | | 23D. ADDRESS
6911 PARK HEIGHTS AVENUE M.D. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | | 24B. DATE
12/19/65 | | 24C. NAME of CEMETERY or CREMATORY
HEBREW FRIENDSHIP | | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 21 1965 | | | 25B. NAME OF REGISTRAR
SOLOMON LEVINSON | | | 25C. FUNERAL DIRECTOR & ADDRESS
BROS. INC. 6010 REISTERSTOWN RD | | | |

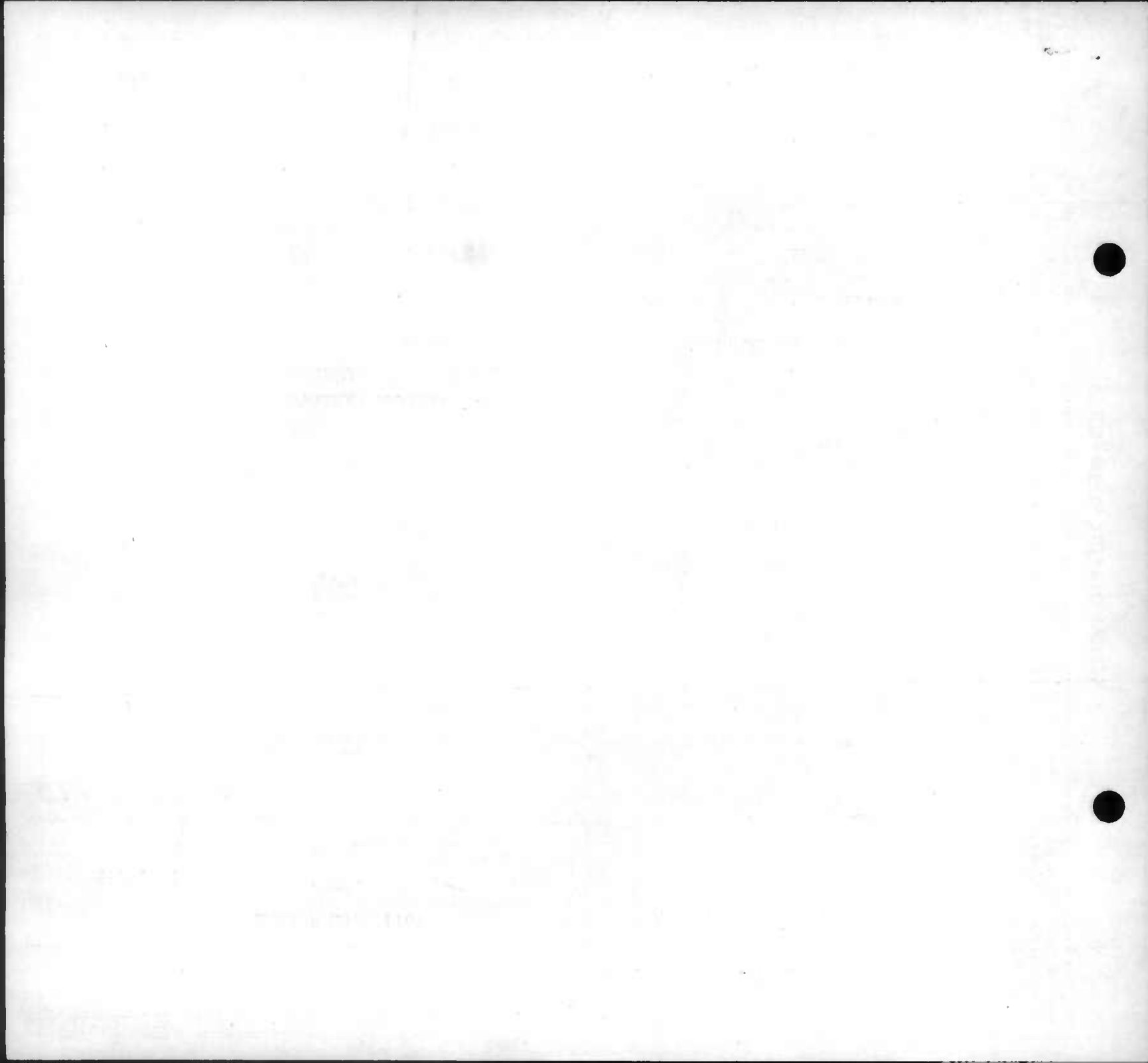


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|---|--|-------------------------|--|--|---|--|--|--|--|---|--|--|--|--|
| BIRTH NO. 65 12956 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 12956 | | | | |
| 1. NAME OF DECEASED
(Type or Print) DAVID SCHULMAN | | | | | 2. DATE AND HOUR OF DEATH
DECEMBER 17, 1965 | | | | | 5:30 P M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
5408 CLOVER ROAD | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 27-17 | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
5408 CLOVER ROAD | | | | | | | | | |
| 5. SEX
MALE | | 6. RACE
WHITE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | | 8. DATE OF BIRTH
1901 | | 9. AGE (In years last birthday)
64 | | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CHAUFFER | | | | | 10B. KIND OF BUSINESS OR INDUSTRY
TAXI CAB | | | | | 11. PLACE (State or foreign country)
RUSSIA | | | | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | 13. FATHER'S NAME
GERSHURN SCHULMAN | | | | | 14. MOTHER'S MAIDEN NAME
UNKNOWN | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
XX NO | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT SCHULMAN
MRS. REBECCA XXXXXX ADDRESS 5408 CLOVER ROAD | | | | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) Coronary Artery Disease
(B) 7 year
(C) INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 59 to Dec 17 19 65 , that (I) (we) last saw the deceased alive on Dec 17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE DR. JOSEPH GROSS M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | | | | | | 23B. DATE SIGNED
12/18/65 | | | | |
| 23C. PHYSICIAN'S NAME (Type)
DR. JOSEPH GROSS M.D. | | | | | | | | | | 23D. ADDRESS
6911 PARK HEIGHTS AVENUE | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | | | 24B. DATE
12/19/65 | | 24C. NAME of CEMETERY or CREMATORY
WORKMENS CIRCLE | | | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE MARYLAND | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 21 1965 | | | | 25B. NAME OF REGISTRAR
DR. JOSEPH GROSS | | | | 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD ADDRESS | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

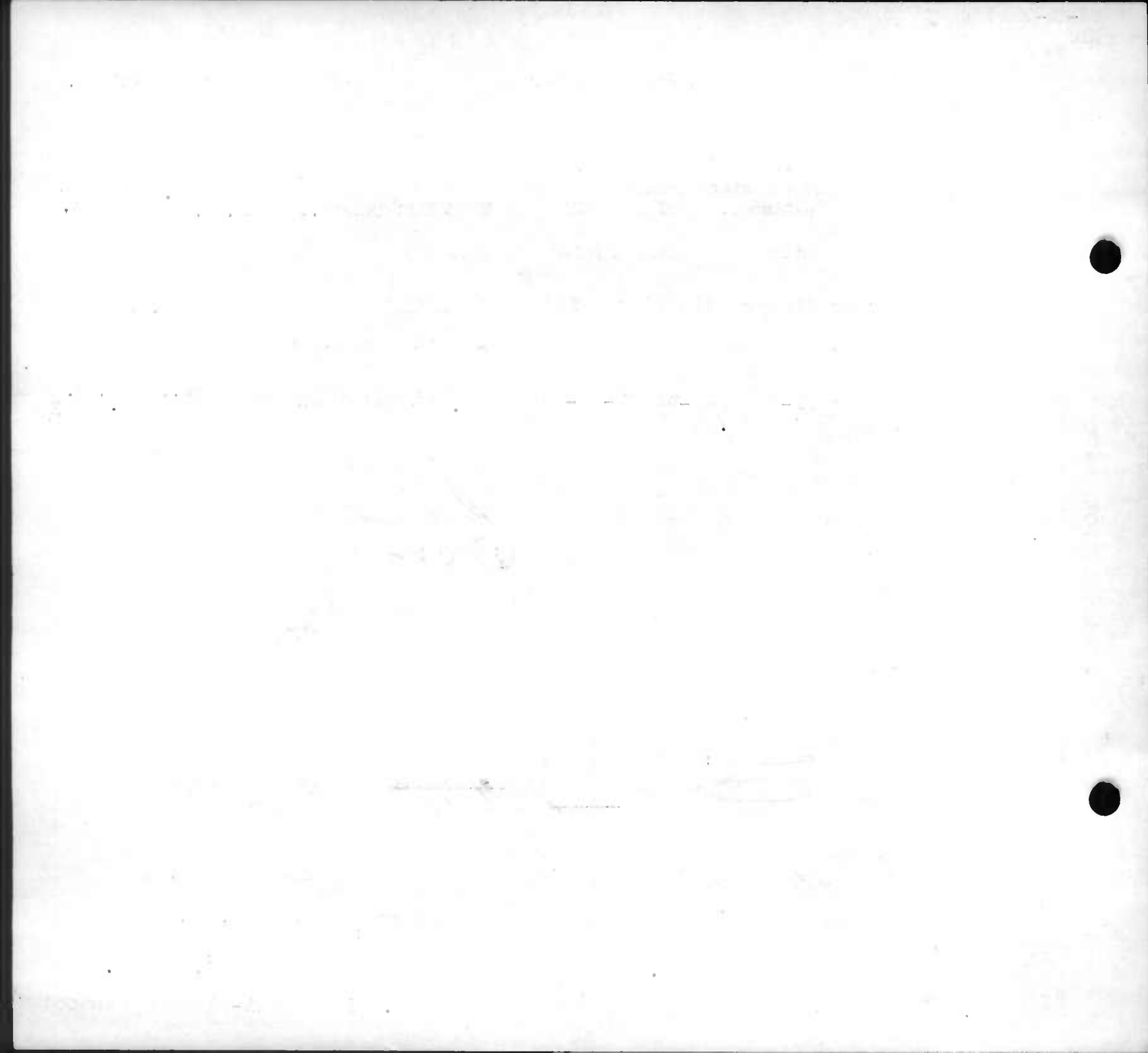
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12957 | |
|---|------------------|--|------------------------------|---|---|
| BIRTH NO.
M.E. CASE NO.
65 12957 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print)
David L. Ford | | 2. DATE AND HOUR OF DEATH
12/15/65 4: P.M. 4: P. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Bon Secours Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY 2884
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
215. Wickham Rd- 21229 | | | |
| 5. SEX
male | 6. RACE
white | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
1-2-1898 | 9. AGE (In years last birthday)
67 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
BALTO. TRANSIT CO. RET. |
| 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | | 13. FATHER'S NAME
David Ford | |
| 14. MOTHER'S MAIDEN NAME
Margaret Hammond | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | 16. SOCIAL SECURITY NO.
215-24-9339 | |
| 17. INFORMANT
HOSPITAL RECORDS | | ADDRESS | | 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
myocardial infarction 3 days
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
A.S.C.V.D. | |
| 19. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/12/1965 to 12/15/1965 that (I) (we) last saw the deceased alive on 12/15/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
J.R. Pezeshkian | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
12/15/65 | |
| 23C. PHYSICIAN'S NAME (Type)
GHOLAM REZA PEZESHKIAN | | 23D. ADDRESS
M.D. BON SECOURS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
12/18/65 | | 24C. NAME OF CEMETERY or CREMATORY
LONDON PARK | |
| 24D. LOCATION (City, town, or county) (State)
BALTO. MD. | | 25A. DATE REC'D BY HEALTH DEPT.
DEC 21 1965 | | 25B. NAME OF REGISTRAR
E. S. MAGNABB | |
| 25C. FUNERAL DIRECTOR
301 FREDERICK AVE 21228 | | ADDRESS | | | |

MEDICAL CERTIFICATION

VS 150-REV. 1/1/65

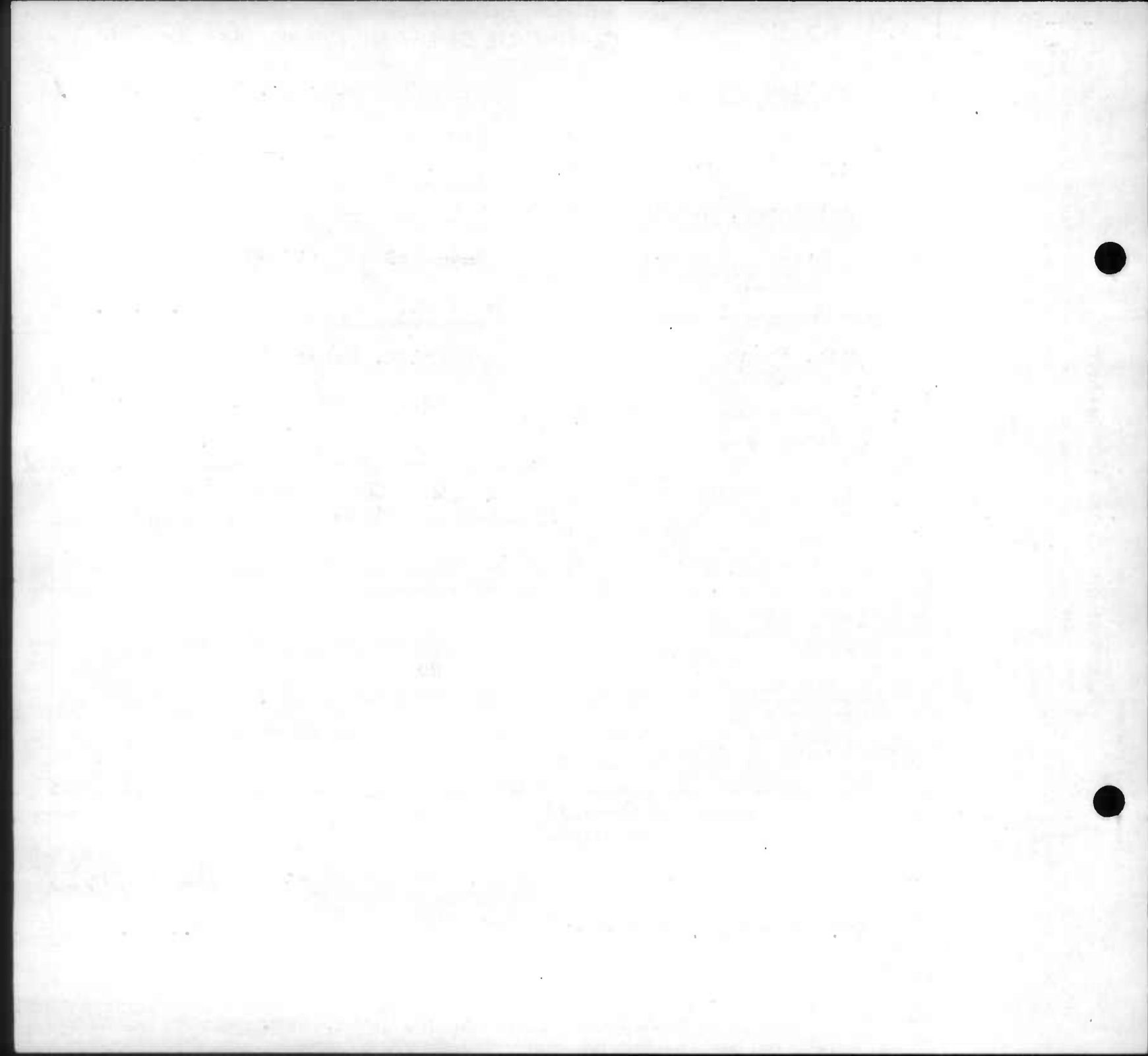


45-34-60 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|---|--|--|
| T-656 65 12959 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 12959 | |
| BIRTH NO. | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| Lillian Turner | | | December 16, 1965 7:30 P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224 | | | Maryland 8-01 | | |
| 5. SEX | | | 6. RACE | | |
| Female | | | White | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | | 8. DATE OF BIRTH | | |
| Married | | | 10-4-1889 | | |
| 9. AGE (In years last birthday) | | | 76 77 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | |
| Housewife | | | Maryland | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Own home | | | U. S. A. | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Seafouth, Frank | | | Frederick, Helen | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| | | | | | |
| 17. INFORMANT | | | ADDRESS | | |
| RECORDS: BCH | | | 4940 Eastern Avenue 21224 | | |
| 18. 260 X I | | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | (A) Cerebral Vascular Accident 1 month | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | (B) Cerebral arteriosclerosis | | |
| ANTECEDENT CAUSES | | | (C) Diabetes Mellitus | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| | | | unknown | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from December 2 19 65 to December 16 19 65, that (I) (we) last saw the deceased alive on Dec. 16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Leonard J. Quadracci | | | | Dec. 16, 1965 | |
| 25C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Dr. Leonard J. Quadracci | | | | 4940 Eastern Avenue Balto., Md. 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 12/20/65 | | Moreland Memorial Park | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| DEC 21 1965 | | Robert C. Altenburg | | -6009 Harford Rd. Funeral Home, Inc. | |

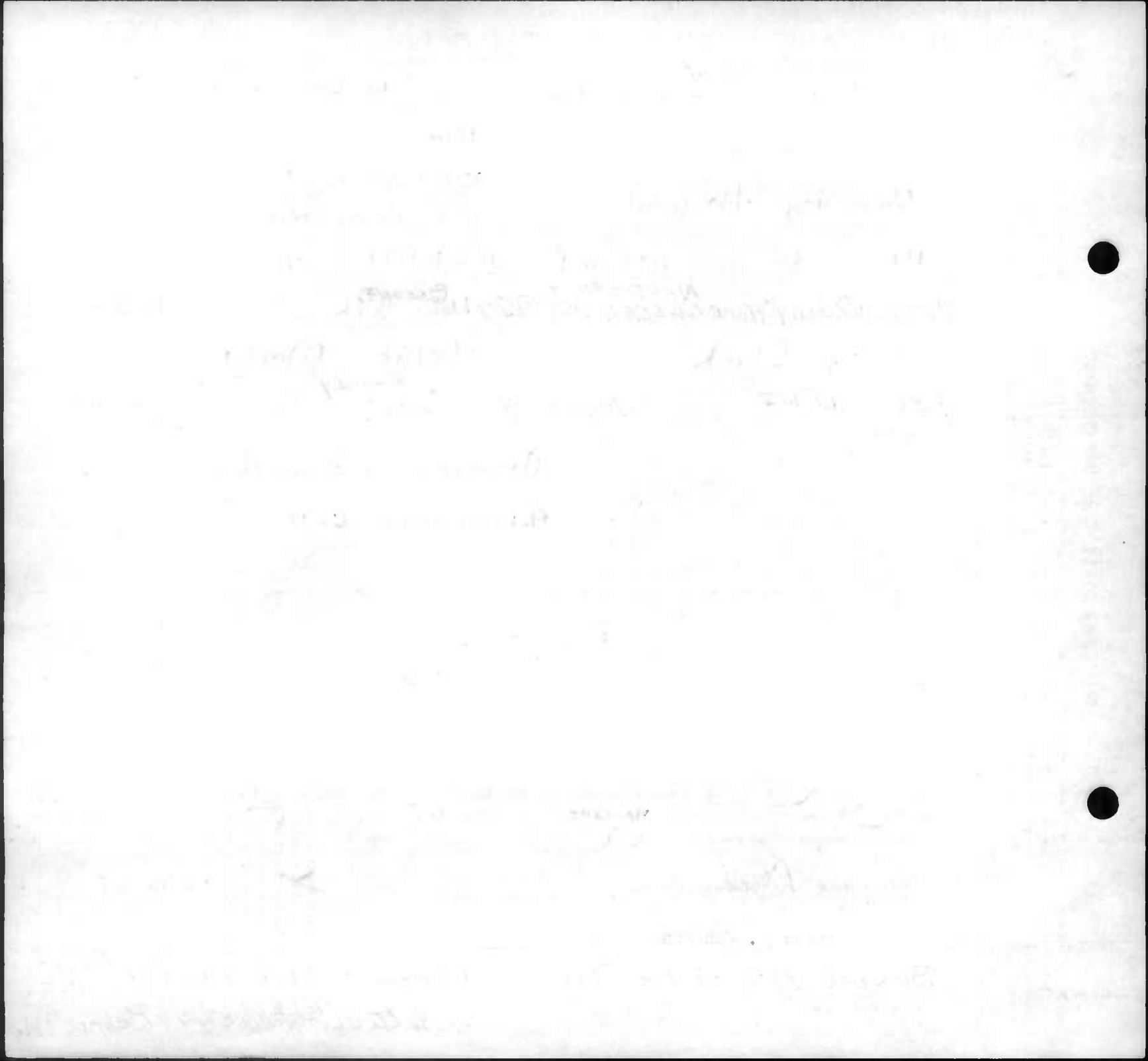


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 65 12960 | |
|--|---------------------|---|--|---|--|---|--|
| BIRTH NO. 65 12960 | | M.E. CASE NO. 65 12960 | | 1. NAME OF DECEASED
(Type or Print) William Clark, Sr. | | 2. DATE AND HOUR OF DEATH
16 December 1965 10:10 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 9-05
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 18
D. STREET ADDRESS (If rural, give location)
708 Homestead St. | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
15 Oct. 1894 | 9. AGE (In years last birthday)
71 | If Under 1 Yr. Months: Days: Hours: Min.
If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED SECURITY OFFICER | | | 10B. KIND OF BUSINESS OR INDUSTRY
MARTINCO + WALTERS ART GALLERY | | 11. BIRTHPLACE (State or foreign country)
GREENE, New York | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Henry Clark | | | 14. MOTHER'S MAIDEN NAME
Lettie Marcy | | | ADDRESS
SAME | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
YES W. WI | | 16. SOCIAL SECURITY NO.
174-10-7589 | | 17. INFORMANT
FAMILY Chort | | ADDRESS
SAME | |
| 18. 422.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Pneumonia | | | | CAUSE OF DEATH
(A) Cerebrovascular hemorrhage
DUE TO
(B) Arteriosclerotic CVD
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
6 days
many yrs
3 days | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>10 Dec 1965</u> to <u>16 Dec 1965</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>16 Dec 1965</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Barbara L. Johnson | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
12-16-65 | |
| 23C. PHYSICIAN'S NAME (Type)
Barbara L. Johnson | | | | 23D. ADDRESS
M.D.
5444 BELAIR RD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
12-20-65 | | 24C. NAME OF CEMETERY or CREMATORY
BALTIMORE NATIONAL | | 24D. LOCATION (City, town, or county) (State)
5501 FREDERICK RD BALTO. MD | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 21 1965 | | 25B. NAME OF REGISTRAR
P. E. E. Johnson | | 25C. FUNERAL DIRECTOR
J. Walter Conklin | | ADDRESS
5444 BELAIR RD. | |



BIRTH NO.

65 12961

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 12961

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ELROY

A.

SCHREIBER

SCHRIEBER-

2. DATE AND HOUR PRONOUNCED DEAD

December 17, 1965

10:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED
 FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
 12-27-65
 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

BALTIMORE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

DUNDALK

21222

D. STREET ADDRESS (If rural, give location)

1950 Wareham Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

OCT. 8, 1908

9. AGE (In years
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MACHINIST

10B. KIND OF BUSINESS OR INDUSTRY

CANNING MFG.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

ADAM SCHRIEBER- Schreiber

14. MOTHER'S MAIDEN NAME

THERESA WOPPMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES.

WW II

16. SOCIAL
SECURITY NO.

212-09-7520

17. INFORMANT

1950 WAREHAM ROAD
 ELEANOR R. SCHRIEBER, DUNDALK, MD. 21222

18. 420.0

CAUSE OF DEATH

Schreiber

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
12/17/6523A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

12/20/1965

23C. NAME OF CEMETERY or CREMATORY

OAK LAWN

23D. LOCATION

(City, town, or county)

(State)

BALTO. CO., MD

24A. DATE REC'D BY HEALTH DEPT.

DEC 21 1965

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

W. BROOKS BRADLEY, DUNDALK, MD.

ADDRESS

VALLEY FORGE

PROBATION

12

12

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

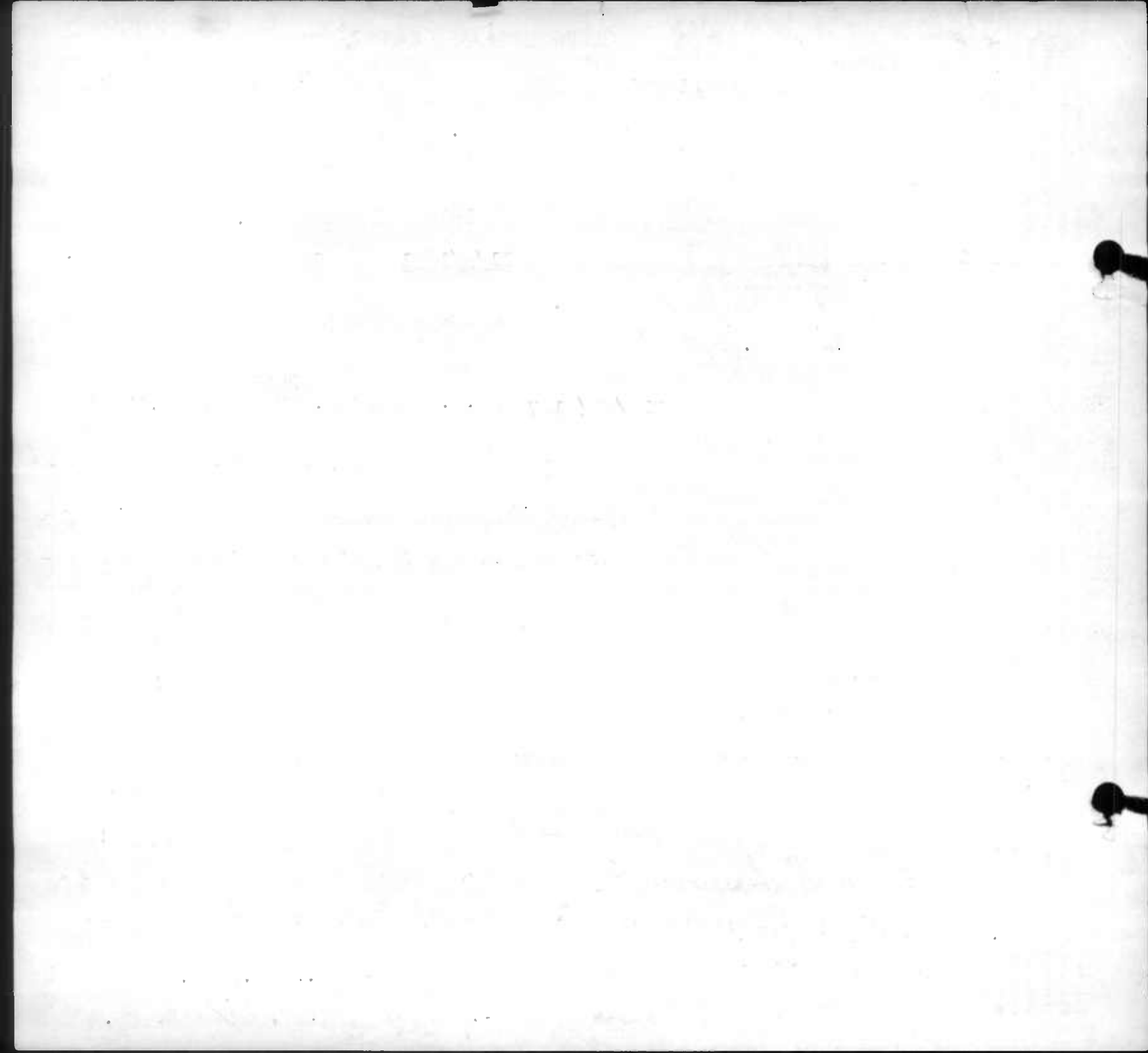
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 65 12962 | |
|---|-----------------------------|--|--|--|--|--|--|
| BIRTH NO. 65 12962 | | | | 1. NAME OF DECEASED
(Type or Print) WILLIAM ALOYSIUS BOYLE | | 2. DATE AND HOUR OF DEATH
12-17-65 8²⁵ P. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
90 TOULD CONVALESCORIUM | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
ROSEDALE 21206
D. STREET ADDRESS (If rural, give location)
1512 NEIGHBORS AVE. | | | |
| 5. SEX
MALE | 6. RACE
CAUCASIAN | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
11/5/1891 | 9. AGE (In years last birthday)
74 | 10. Under 1 Yr. Months: Days: Hours: Min.
11. Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MACHINIST | | | 10B. KIND OF BUSINESS OR INDUSTRY
CANNING MFG. | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
WILLIAM D. BOYLE | | | | 14. MOTHER'S MAIDEN NAME
MARY ADAMS | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | 16. SOCIAL SECURITY NO.
212/09/5187 | | 17. INFORMANT
WM. A. BOYLE, JR. 2467 FAIRWAY DUNDALK, MD. 21222 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) MASSIVE MYOCARDIAL INFARCT 12-17-65
DUE TO
(B) ACUTE CORONARY THROMBOSIS 11-28-62
DUE TO
ARTERIO SCLEROTIC C.V. DISEASE 11-28-62 | | | |
| | | | | INTERVAL BETWEEN ONSET AND DEATH
NONE | | | |
| | | | | 19A. DATE OF OPERATION
NONE | | | |
| | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
NONE | | | |
| 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
NONE | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
NONE | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
NONE | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NONE | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)
NONE | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> IV Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
NONE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-28-62 19 to 12-17-65 19 that (I) was last saw the deceased alive on Nov. 27 19 65 and that in (my) one opinion death occurred on the date and hour and from the causes stated above. (I) Was (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
E. A. Schimunek | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
12-18-65 | |
| 23C. PHYSICIAN'S NAME (Type)
E. A. SCHIMUNEK | | | | 23D. ADDRESS
842 S. EAST AVE. BALTO. MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
12/21/65 | | 24C. NAME of CEMETERY or CREMATORY
OAKLAWN | | 24D. LOCATION (City, town, or county) (State)
BALTO., CO., MD. | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 21 1965 | | 25B. NAME OF REGISTRAR
W. BROOKS BRADLEY | | 25C. FUNERAL DIRECTOR
W. BROOKS BRADLEY, DUNDALK, MD. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 65 12963

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Richard N. Davidson

2. DATE AND HOUR OF DEATH

12/17/65 9:30 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

421 S. Parrish St.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

421 S. Parrish St.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

9. AGE (In years
last birthday)

September 4, 1904 61

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Truck Driver

10B. KIND OF BUSINESS OR INDUSTRY

meat

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John L. Davidson

14. MOTHER'S/MAIDEN NAME

Margaret Leazier

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-10-0381

17. INFORMANT

S. Annis Davidson 421 Parrish St

ADDRESS

18. 420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, osthenio, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) Coronavirus thrombosis
DUE TO

(B) Arteriosclerosis c. v. etc.
DUE TO severe, Bronchial asthma
(C) Chronic Bronchitis, Emphysema pul.

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 21 1962 to Nov. 27 1965,
that (I) (we) last saw the deceased alive on December 17 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Albinas Klimas M.D.

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

12-18-65

23C. PHYSICIAN'S
NAME (Type)

ALBINAS KLIMAS

23D. ADDRESS

2030 Wilkens Ave, Baltimore MD 21223

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12/20/65

24C. NAME OF CEMETERY or CREMATORY

Schwartz Cemetery

24D. LOCATION

Baltimore, Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 21 1965

25B. NAME OF REGISTRAR

John E. Johnson

25C. FUNERAL DIRECTOR

W. P. S. Funeral Home & Path & Stricker

ADDRESS

Geometric Theorems

Book 1, Propositions 1-26
Book 2, Propositions 1-14
Book 3, Propositions 1-19
Book 4, Propositions 1-16
Book 5, Propositions 1-24
Book 6, Propositions 1-33
Book 7, Propositions 1-23
Book 8, Propositions 1-27
Book 9, Propositions 1-36
Book 10, Propositions 1-47
Book 11, Propositions 1-38
Book 12, Propositions 1-21
Book 13, Propositions 1-18

Page 11 of 12

Algebra Kline
2030 Wilshire Ave, Los Angeles, CA 90060

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

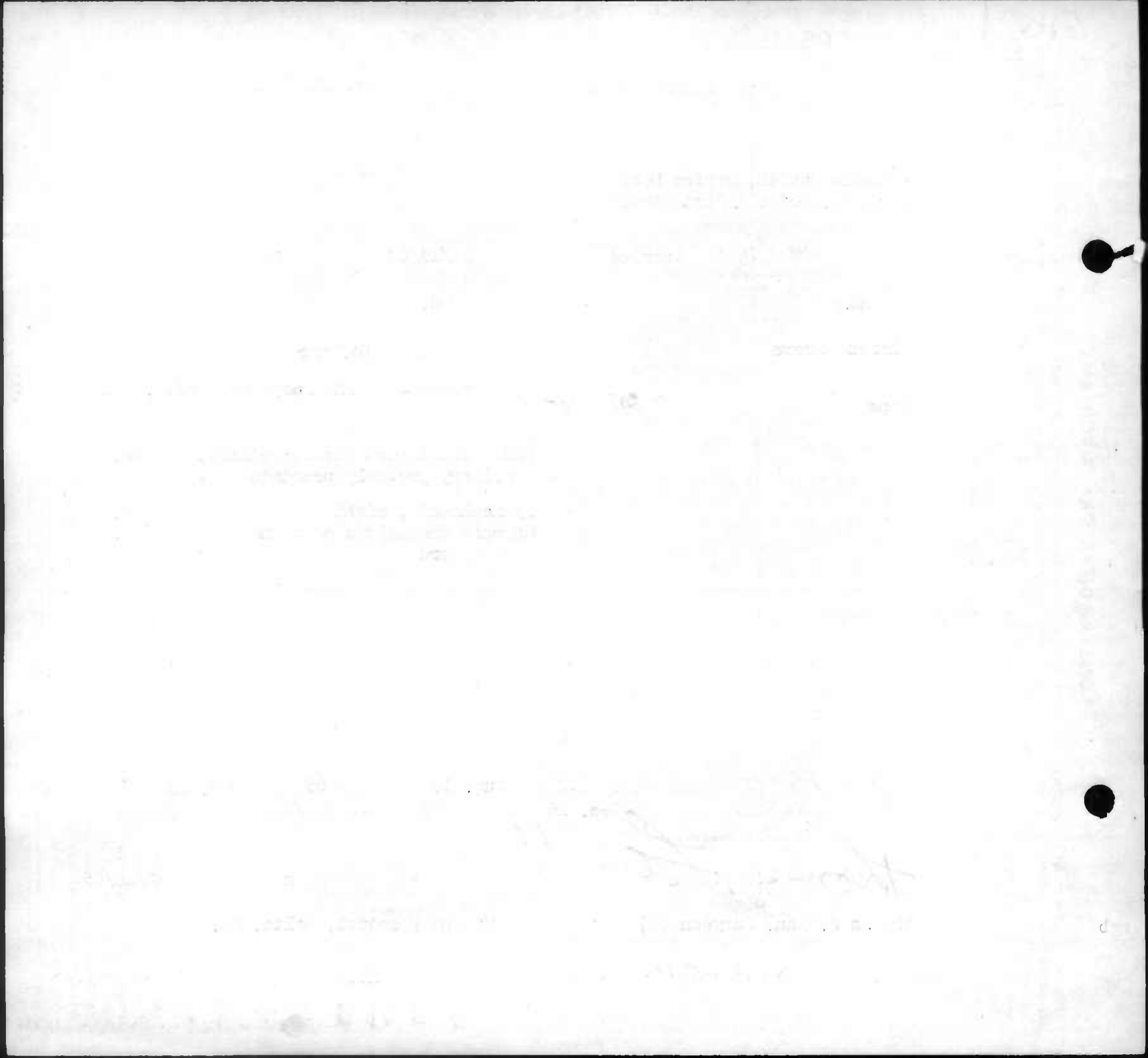
| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 12964 | | CERTIFICATE OF DEATH | | Registered No. 65 12964 | |
|--|---|--|--|---|--|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) George R. Bogan | | | | 2. DATE AND HOUR OF DEATH
12/16/65 6:15 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
37 Mercy Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 6-04
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Balto.
D. STREET ADDRESS (If rural, give location)
23 N. Ann St. | | | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
2-17-17 | | 9. AGE (In years last birthday)
48 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Welder | | 10B. KIND OF BUSINESS OR INDUSTRY
Machine Co. | | 11. BIRTHPLACE (State or foreign country)
Richman, North Carolina | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
Walter H. Bogan | | | | 14. MOTHER'S MAIDEN NAME
Sallie P. O'Quinn | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
241-07-3825 | | 17. INFORMANT ADDRESS
Mrs. Ruth Bogan 23 N. Ann Street | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
053.4 + 1581.1
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) Acute pulmonary edema
DUE TO
(B) Lobar pneumonia + septicemia
DUE TO RLL, RML, LLL.
(C) ASCVD, dehydration, Laennec's cirrhosis | | | | INTERVAL BETWEEN ONSET AND DEATH
12 hrs.
5 days. | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
ASCVD, dehydration, Laennec's cirrhosis | | | | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/16 19 65 to 12/16 19 65 , that (I) (we) last saw the deceased alive on 12/16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
E. L. Robbins M.D. | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
12/16/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS
M.D. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Removal | | 24B. DATE
Dec. 17, 1965 | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State)
Rockingham North Carolina | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 21 1965 | | 25B. NAME OF REGISTRAR
Robert E. Johnson | | 25C. FUNERAL DIRECTOR ADDRESS
Wm. Cook-Brooks, Inc. 1217 St. Paul Street | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

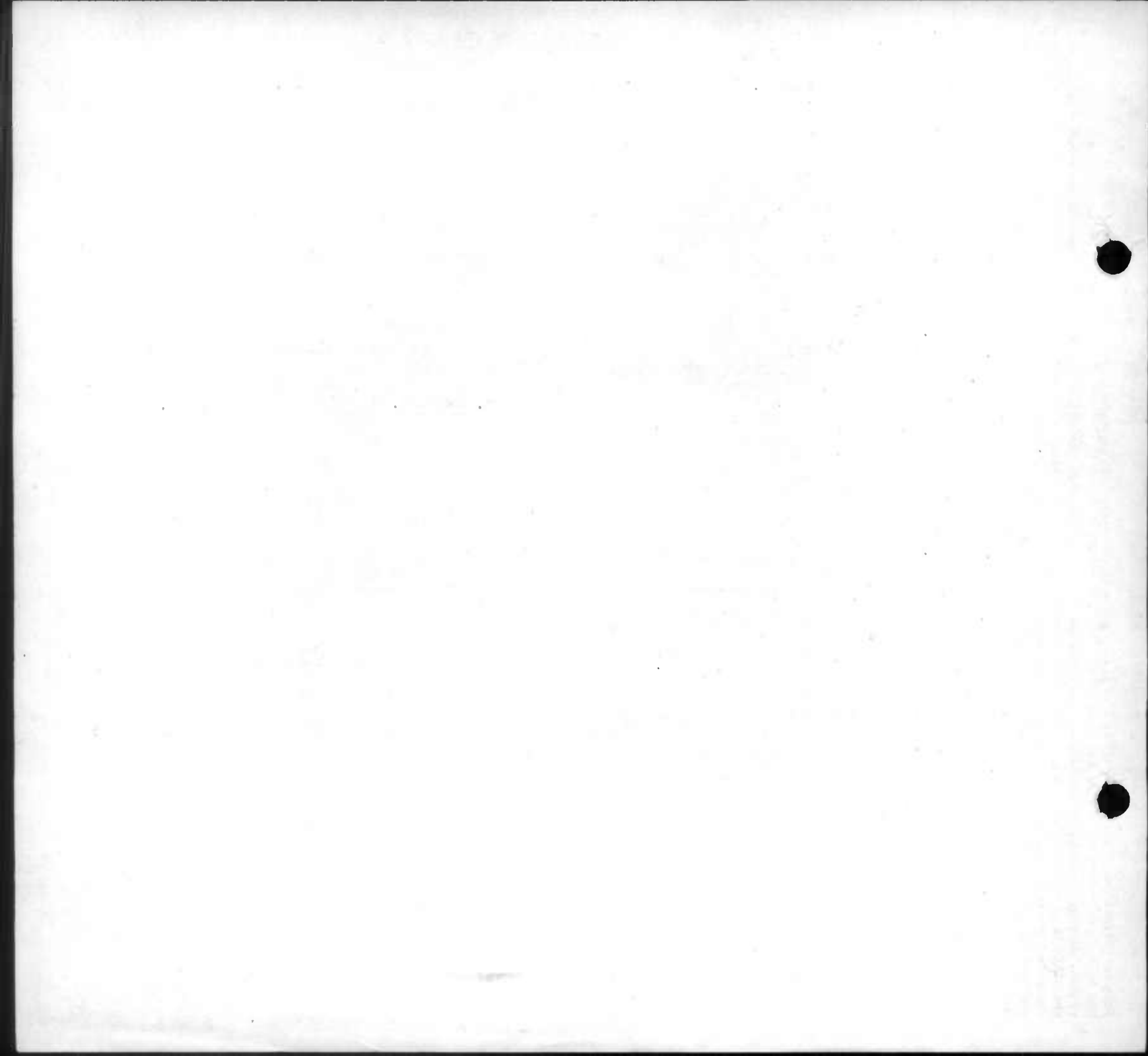
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12965 | |
|--|---------------------|--|---|---|--|
| BIRTH NO. 65 12965 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) Earl Thomas Shreve | | | | Dec. 16, 1965 5:38 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE Md.
B. COUNTY Montgomery | |
| US Public Health Service Hospital
Wyman Pk. Drive & 31st Street | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Dickerson
65-00 | |
| D. STREET ADDRESS (If rural, give location) | | | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
11/15/09 | 9. AGE (In years last birthday)
56 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Md. | |
| 13. FATHER'S NAME
Thomas Shreve | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 14. MOTHER'S MAIDEN NAME
Stella Heffner | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
None | | | 16. SOCIAL SECURITY NO.
318-347-5371 | | |
| 17. INFORMANT
Records- US PHS Hospital, Balto, Md. | | | ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Undifferentiated adenocarcinoma, primary probably prostate | | | INTERVAL BETWEEN ONSET AND DEATH
Mos. | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Pyonephrosis, right Chronic meningitis of spinal cord | | | Mos.
Mos. | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from Aug. 10 19 65 to Dec. 16 19 65 , that (1) (we) last saw the deceased alive on Dec. 16 19 65 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Thomas J. Lau | | | | 23B. DATE SIGNED
12/16/65 | |
| 23C. PHYSICIAN'S NAME (Type)
Thomas J. Lau, Surgeon (R) | | | | 23D. ADDRESS
US PHS Hospital, Balto, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
Dec 18-65 | | 24C. NAME OF CEMETERY or CREMATORY
Monocacy | |
| 24D. LOCATION (City, town, or county) (State)
Beallsville, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 21 1965 | | 25B. NAME OF REGISTRAR
W. J. Hill | | 25C. FUNERAL DIRECTOR
W. J. Hill | |
| ADDRESS | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------|--|------------------|--|---|
| 65 12966 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 65 12966 | |
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) | | Mildred R. Fisher | | December 19, 1965 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | M. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | Maryland | | 12-02 | |
| 3502 Clifton Avenue
Clifton Nursing Home
Baltimore, Maryland 21216 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| | | D. STREET ADDRESS (If rural, give location) | | 3024 North Calvert Street 18 | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| Female | White | Divorced | 2/18/1895 | 70 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Retired - School | | Teacher | | Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| John Reiser | | Alice Noyes Wilburn | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | None | | Prospect Park Plaza | |
| | | | | Mr. John R. Martin Frederick, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 420.1 I | | Coronary Thrombosis Sudden | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | | |
| ANTECEDENT CAUSES | | (B) DUE TO | | Chronic myocardial degeneration? | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | Hepatic cirrhosis? | |
| II | | Hepatic cirrhosis | | ? | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct. 3, 1965 to Dec. 19, 1965. that (I) lost saw the deceased alive on Dec. 19, 1965 and that in my opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Maurice E. Okamer M.D. | | | | Dec. 20, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| | | 3300 W. North Ave, Balto. Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Cremation | | 12/22/1965 | | Loudon Park Crematory | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| DEC 21 1965 | | Robert E. Fisher | | Wm. J. Fisher - 800 North Park Ave. Balto. Md. 17 | |

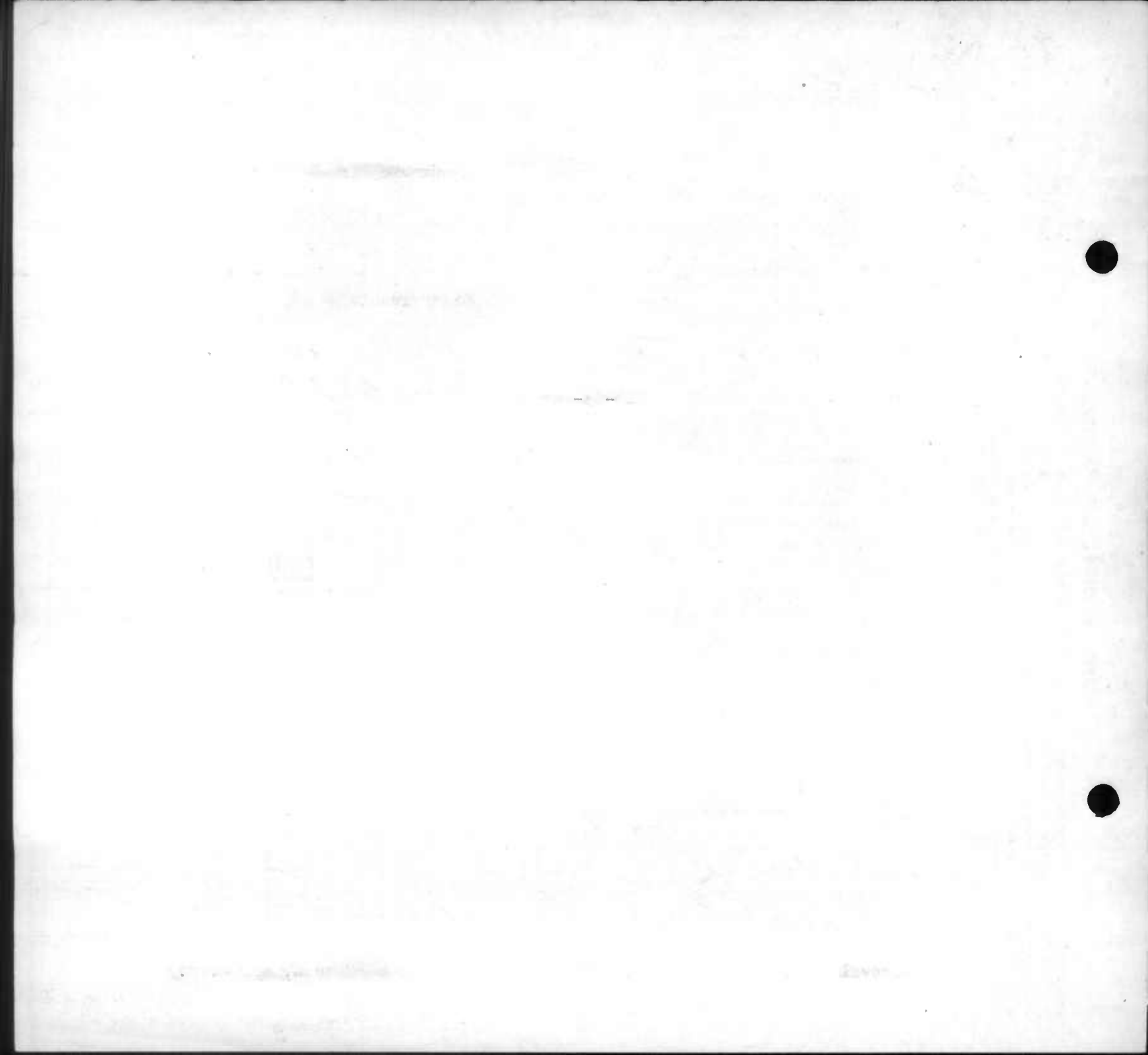


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 12967 | |
|---|--|--|--|--|--|--|--|
| BIRTH NO. 65 12967 | | M.E. CASE NO. 65 12967 | | | | | |
| 1. NAME OF DECEASED
(Type or print) <u>ALICE S. DAVIS</u> | | | | 2. DATE AND HOUR OF DEATH
<u>12/20/65</u> <u>5:20</u> <u>a</u> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>University Hospital BALTO 1, Md.</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>md</u> B. COUNTY <u>Baltimore</u> | | | |
| 5. SEX <u>F</u> | | 6. RACE <u>W</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>married</u> | | 8. DATE OF BIRTH
<u>5/26/84</u> | |
| 9. AGE (In years last birthday)
<u>81</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>James ALBERT STARKY</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Preole, Lillie H.</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>216-03-4845 B</u> | | 17. INFORMANT
<u>Husband</u> | | ADDRESS
<u>same</u> | |
| 18. <u>170X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Carcinomatous</u>
<u>Ca of breast</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) <u>Carcinomatous</u>
DUE TO
(B) <u>Ca of breast</u>
DUE TO
(C) _____ | | | |
| 19A. DATE OF OPERATION
<u>None</u> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
_____ | | 20A. AUTOPSY? (Yes or No)
<u>no</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
_____ | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
_____ | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
_____ | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
_____ | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/2/65</u> 19 to <u>12/20</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12/19</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Robert M. Byers</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>12/20/65</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Robert M. BYERS</u> | | | | 23D. ADDRESS
M.D. <u>University Hospital</u> | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
<u>Removal</u> | | 24B. DATE
<u>12/23/1965</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Harleigh</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Camden, New Jersey</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>DEC 21 1965</u> | | 25B. NAME OF REGISTRAR
<u>RECEIVED</u> | | 25C. FUNERAL DIRECTOR
<u>Wm. F. Tichner & Sons</u> | | | |
| ADDRESS
<u>Balto, Md. 17 north + Pacific</u> | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. <u>65 12968</u> | |
|---|-------------------------|---|---|--|---------------------------------|--|-----------------------------|
| BIRTH NO. <u>65 12968</u> | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>ANDERTON ROSA</u> | | 2. DATE AND HOUR OF DEATH
<u>DECEMBER 12, 1965 4:05 P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>NORTH CHARLES GENERAL HOSP.</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY <u>6-04</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u>
D. STREET ADDRESS (If rural, give location)
<u>206 NORTH CHAPEL STREET</u> | | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>WIDOWED</u> | 8. DATE OF BIRTH
<u>77</u> | 9. AGE (In years last birthday)
<u>77</u> | If Under 1 Yr.
Months: Days: | If Under 24 Hrs.
Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>RETIRED</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>none</u> | | 11. BIRTHPLACE (State or foreign country)
<u>GERMANY</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | |
| 13. FATHER'S NAME
<u>Lammerhirt</u> | | | 14. MOTHER'S MAIDEN NAME
<u>----</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>---</u> | | 16. SOCIAL SECURITY NO.
<u>212-05-7875</u> | | 17. INFORMANT
<u>MINNIE MAULER</u> | | | ADDRESS
<u>CHASE, Md</u> |
| 18. <u>443X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
<u>CONGESTIVE HEART FAILURE</u>
<u>ATRIAL FIBRILLATION</u>
<u>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <u>W</u> (this hospital) attended the deceased from <u>DECEMBER 7</u> 19 <u>65</u> to <u>DECEMBER 12</u> 19 <u>65</u> , that <u>W</u> (we) last saw the deceased alive on <u>DECEMBER 12</u> 19 <u>65</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>W</u> (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Melita M. Toner</u> M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>DECEMBER 12, 1965</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>J. M. MILLER</u> | | | 23D. ADDRESS
M.D. <u>1613 EAST BALTIMORE ST, BALTO</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>Dec. 16/65</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Balto. Nat. Cem.</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Balto. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>DEC 21 1965</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Johnson</u> | | 25C. FUNERAL DIRECTOR
<u>Philip H. Hargis</u> | | ADDRESS
<u>2024 Orleans St</u> | |

10-10-1944

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| BIRTH NO.
M.E. CASE NO. | | 65 12969 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 12969 | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| William James Brown | | | | 5:10 AM 12/19/65 M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| University Hospital | | | | Md 1702 | | | |
| 5. SEX | | | | 6. RACE | | | |
| M | | | | N | | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | | | 8. DATE OF BIRTH | | | |
| W | | | | 11/6/04 | | | |
| 9. AGE (In years lost birthday) | | | | 10. CITIZEN OF WHAT COUNTRY? | | | |
| 61 | | | | PAID | | | |
| 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| PAID | | | | PAID | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Wm. Brown | | | | Henrietta Butler | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| | | | | 5619 Sullivan Ave. | | | |
| 17. INFORMANT | | | | ADDRESS | | | |
| Mr. William Brown | | | | 5619 Sullivan Ave. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | |
| II | | | | Hypertension | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Mediastinal Tumor | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | Yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 12/13 1965 to 12/19 1965 | | that (1) (we) lost saw the deceased alive on 12/18 1965 | | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Bruce A. Brian | | | | 12/19/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| BRUCE A. BRIAN | | | | University Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 12/22/65 | | Family lot | | Edgewater, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| DEC 21 1965 | | R. A. Brian | | 10510 Walnut Hill Ave. | | | |

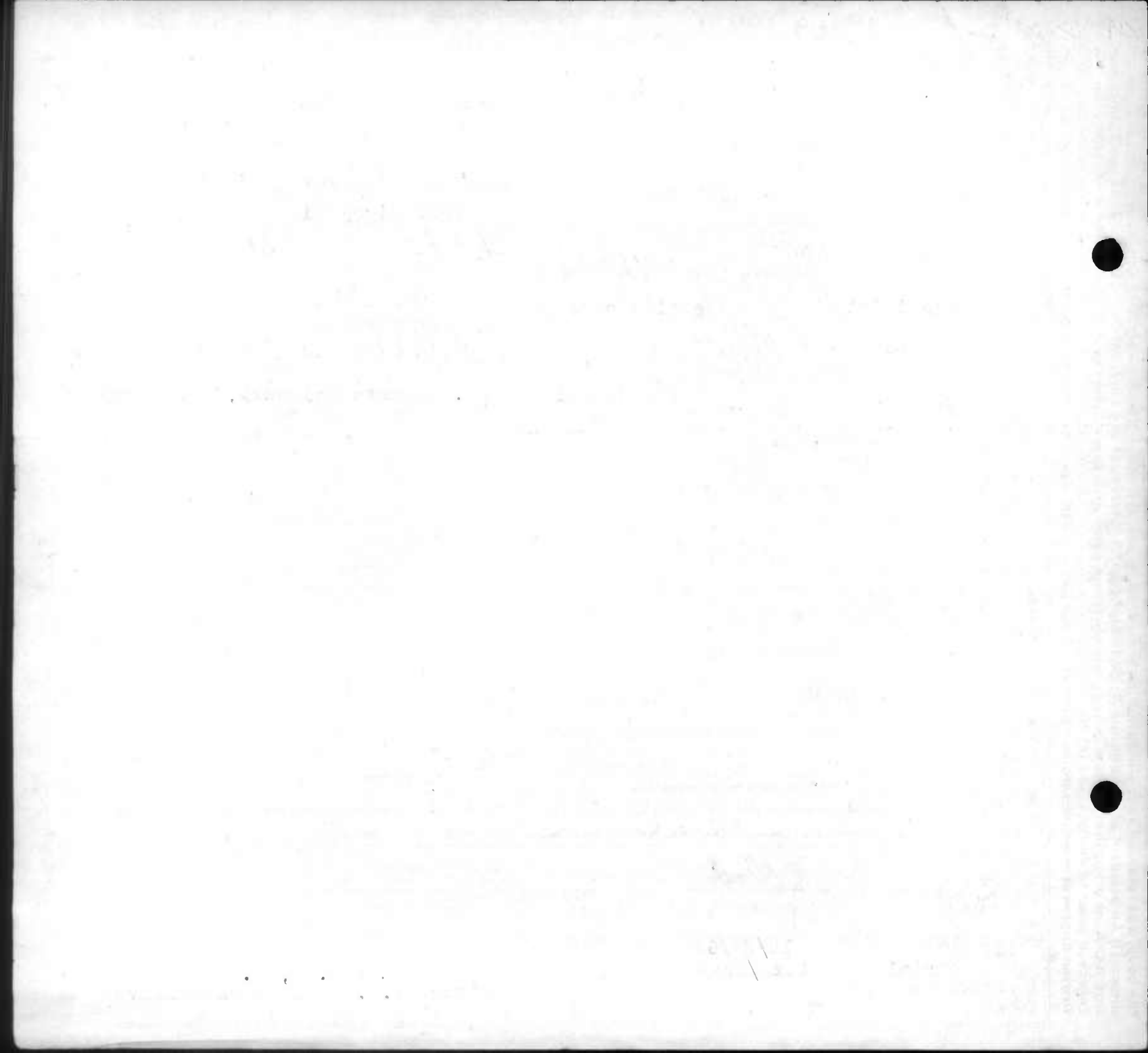
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 12970 | |
|---|-------------------------|--|--|---|---|
| BIRTH NO. 12/65 12970 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | Registered No. | |
| 1. NAME OF DECEASED
(Type or Print) <i>Majeczky Wm. A.</i> | | | 2. DATE AND HOUR OF DEATH
<i>12/18/65 6:10 P.M.</i> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>24 Bon Secours hospital</i> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Baltimore, Maryland</i>
B. COUNTY <i>Baltimore</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>7509 Digby Road #7</i>
D. STREET ADDRESS (If rural, give location)
<i>7509 Digby Rd 5300</i> | | |
| 5. SEX
<i>Male</i> | 6. RACE
<i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>MARRIED</i> | 8. DATE OF BIRTH
<i>4-27-04</i> | 9. AGE (in years last birthday)
<i>61</i> | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Machinist</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Westinghouse</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Hungary</i> | |
| 13. FATHER'S NAME
<i>Henry A. Majeczky</i> | | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>UNKNOWN</i> | | | 16. SOCIAL SECURITY NO.
<i>705 03 9115</i> | | |
| 17. INFORMANT
<i>Mrs. Augusta Majeczky</i> | | | ADDRESS
<i>7509 Digby Rd</i> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) DUE TO
<i>CA of the Lung</i>
(B) DUE TO
(C) DUE TO | | |
| 19. DATE OF OPERATION
<i>12/18/65</i> | | | 20. AUTOPSY? (Yes or No) | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR? | | | 21G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Dec. 15, 1965</i> to <i>Dec. 18, 1965</i> , that (I) (we) last saw the deceased alive on <i>Dec. 18, 6:10 PM</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | 23B. DATE SIGNED
<i>Dec. 18, 1965</i> | | |
| 23A. SIGNATURE
<i>Byong Hack Kim</i> | | | 23C. PHYSICIAN'S NAME (Type)
<i>BYONG HACK KIM</i> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>burial</i> | | | 24B. NAME OF CEMETERY or CREMATORY
<i>12288 65 Woodlawn</i> | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>DEC 21 1965</i> | | | 25B. NAME OF REGISTRAR
<i>2.5 6.3</i> | | |
| 25C. FUNERAL DIRECTOR
<i>11500</i> | | | 25D. ADDRESS
<i>4101 Edmondson Ave</i> | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 12971 | |
|--|---------------------|--|---|--|--|--|--|
| BIRTH NO. 65 12971 | | M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Wm. P. Hayden</i> | | | | 2. DATE AND HOUR OF DEATH
<i>Dec. 19/65</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Md.</i> B. COUNTY <i>AA</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>So. Boro. Gen'l Hosp</i> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Linthicum</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<i>1300 N. Old Annapolis Rd.</i> | | | |
| 5. SEX
<i>male</i> | 6. RACE
<i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>Married</i> | 8. DATE OF BIRTH
<i>May 14, 1901</i> | 9. AGE (In years last birthday)
<i>64</i> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Retired</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Md.</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> |
| 13. FATHER'S NAME
<i>late Richard J. Hayden</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>late Susanna Higgs</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO.
<i>213 20 8556</i> | | 17. INFORMANT ADDRESS
<i>Mrs. Matilda Hayden, Linthicum, Md</i> | | |
| 18. <i>420.11</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) <i>Acute Myocardial Infarction</i>
DUE TO
(B) <i>Arteriosclerotic Heart Disease</i>
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
<i>minute</i>
<i>3-4 yrs</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>March</i> 19 <i>65</i> to <i>12-19</i> 19 <i>65</i> , that (I) (we) lost saw the deceased alive on <i>November 24</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Hilary T O'Herlihy</i> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<i>12-20-65</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>HILARY T O'HERLIHY</i> | | | | 23D. ADDRESS
<i>5 CENTRAL AVE, Glen Burnie Md.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>burial</i> | | 24B. DATE
<i>12/23/65</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Balto. National</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Balto. Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>DEC 21 1965</i> | | 25B. NAME OF REGISTRAR
<i>W. P. Zick</i> | | 25C. FUNERAL DIRECTOR
<i>W. P. Zick</i> | | ADDRESS
<i>4101 Edmondson Ave</i> | |

State Department
Washington, D.C.

Received
May 10 1964

6

Henry T. O'Connell
1000 17th St. N.W.
Washington, D.C.

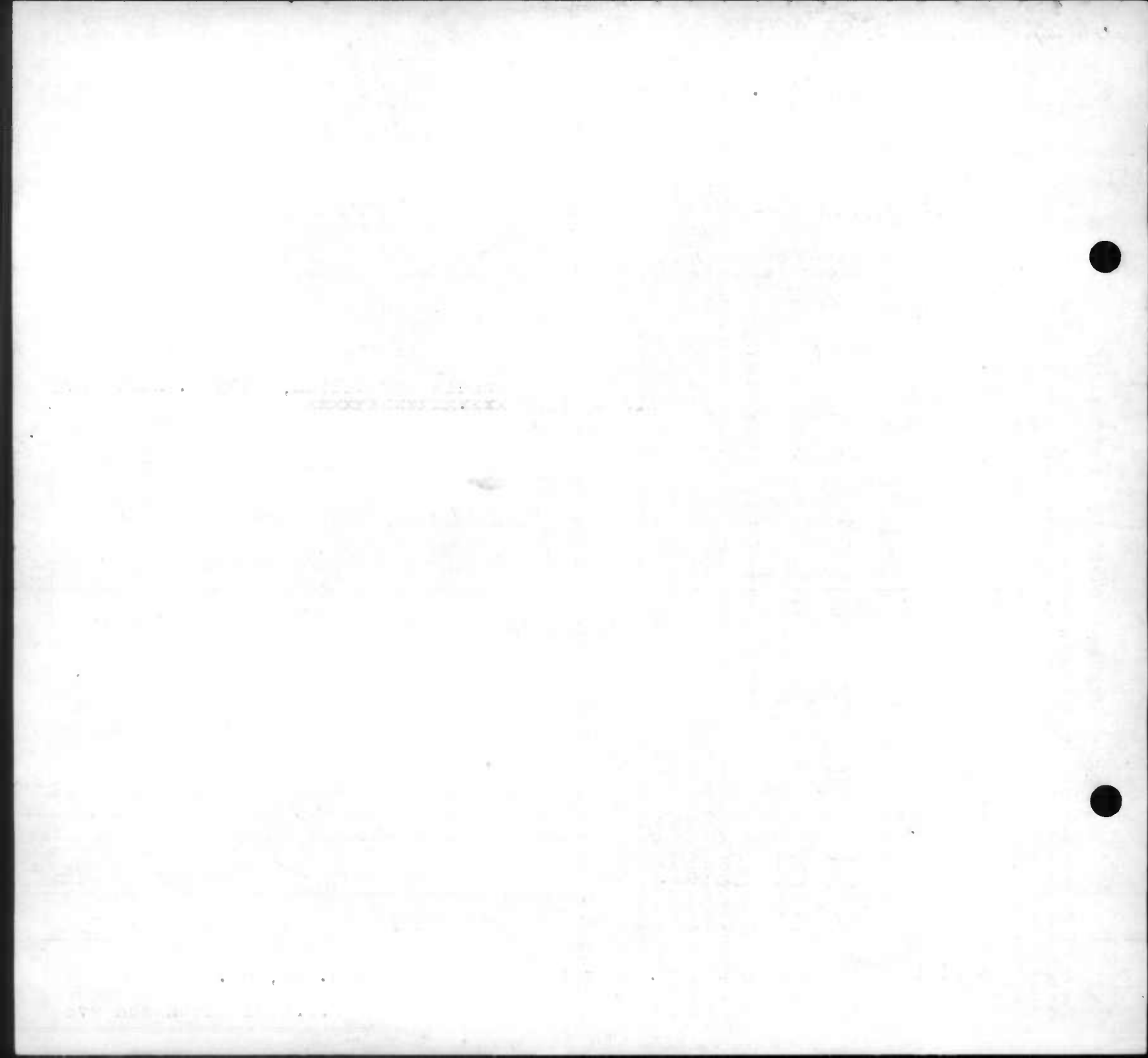
2 CENTER PVE

John Brown

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

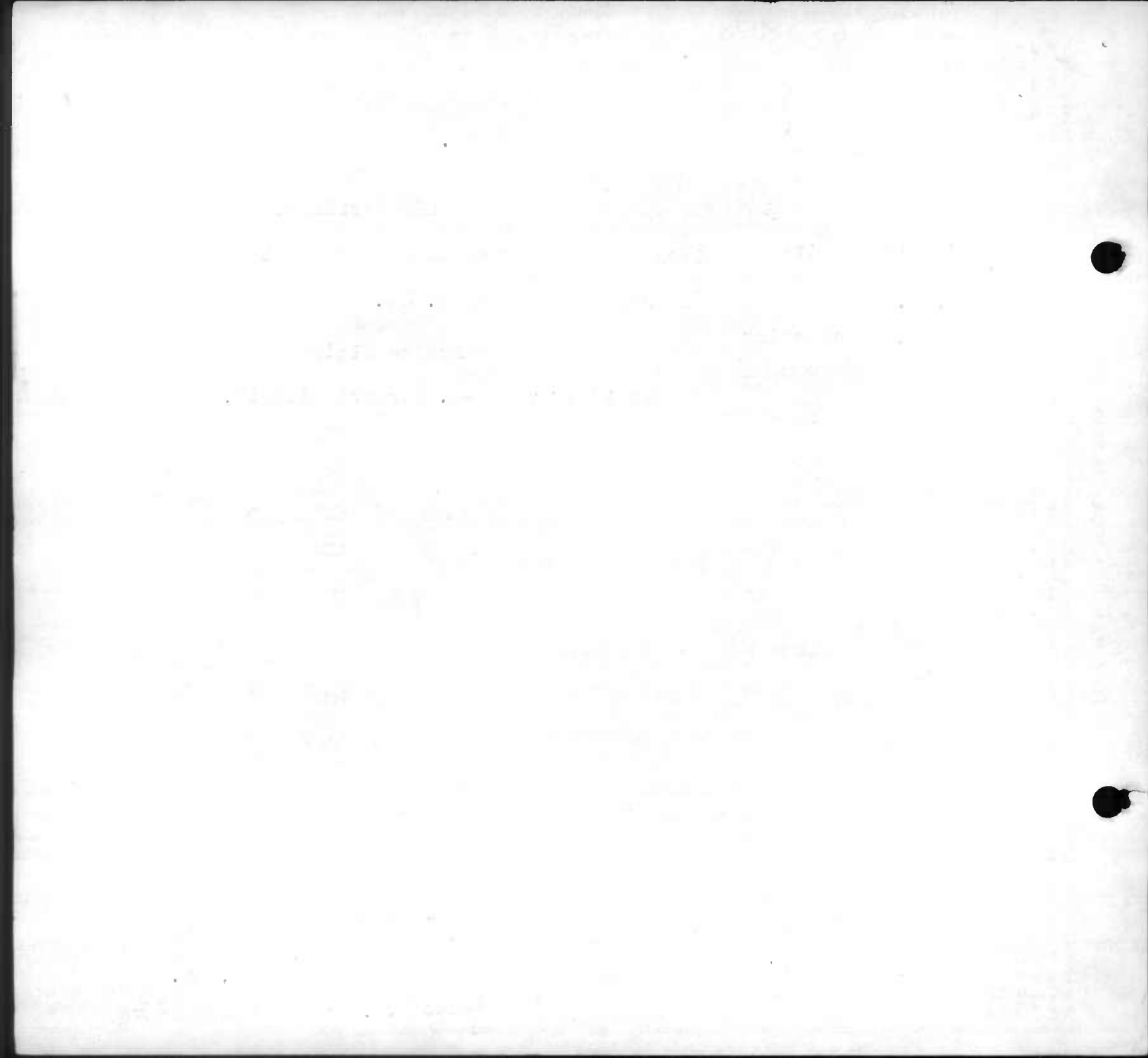
| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 12972 | |
|--|---|---|---|--|--|--|---|
| BIRTH NO. 3 65 12972 | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Dorothy V. Vermillion | | | | 2. DATE AND HOUR OF DEATH
18-Dec 65 7 18 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
MARYLAND GENERAL Hospital | | | | A. STATE MARYLAND | | | |
| | | | | B. COUNTY Baltimore | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 21207 6300 | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
5500 W. North Ave. | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
DIVORCED | 8. DATE OF BIRTH
6/3/10 | 9. AGE (In years last birthday)
55 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife - | | 11. BIRTHPLACE (State or foreign country)
Penna |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Richard E Sands | | | | 14. MOTHER'S MAIDEN NAME
Martha E. Donovan | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
219 20 7198 | | 17. INFORMANT ADDRESS
Donald Vermillion, 5500 W. North Ave | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
420.1 I | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO
Cerebral embolism | | 24 hr - | |
| | | | | (B) DUE TO
Myocardial Infarction | | 7 days | |
| | | | | (C) DUE TO
ARTERIOSCLEROTIC Cardiovascular Disease | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Hypothyroidism | | | | | | 16 YEARS | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 11 Dec 19 65 to 18 Dec 19 65 , that (2) (we) last saw the deceased alive on 18-Dec 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
J. C. Cullis MD | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
18-Dec-65 | |
| 23C. PHYSICIAN'S NAME (Type)
J. C. Cullis | | | | 23D. ADDRESS
MARYLAND General Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12/22/65 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Olivet | | 24D. LOCATION (City, town, or county) (State)
Balto. 23, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 21 1965 | | 25B. NAME OF REGISTRAR
Robert E. [unclear] | | 25C. FUNERAL DIRECTOR
W. [unclear] | | ADDRESS
F.D. 4101 Edmondson Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|-------------------------|---|--------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT | | REGISTERED NO. 65 12973 | |
| BIRTH NO. 65 12973 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) <i>Flora R. Lutz</i> | | 2. DATE AND HOUR OF DEATH
<i>Dec 19/65</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Md.</i> B. COUNTY <i>25-31</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
<i>Hood Nursing Home</i>
<i>5313 Edmondson Ave</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | |
| D. STREET ADDRESS (If rural, give location)
<i>343 Martingale Ave</i> | | | |
| 5. SEX
<i>Female</i> | 6. RACE
<i>White</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Widow</i> | 8. DATE OF BIRTH
<i>May 22/94</i> |
| 9. AGE (In years last birthday) <i>71</i> | | 10. If Under 1 Yr. Months: Days If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>H. W.</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>O'n Home</i> | |
| 11. BIRTHPLACE (State or foreign country)
<i>Balto. Md.</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 13. FATHER'S NAME
<i>Adolph Wobbeking</i> | | 14. MOTHER'S MAIDEN NAME
<i>Franceska Klair</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>215 10 7057</i> | | 16. SOCIAL SECURITY NO.
<i>215 10 7057</i> | |
| 17. INFORMANT
<i>Mrs. Herbert Wilhelm</i> | | ADDRESS
<i>343 Martingale R</i> | |
| 18. <i>442X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>UREMIA</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>2 years</i> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<i>HYPERTENSIVE - Cardiovascular</i>
<i>renal disease</i> | | <i>5 years</i> | |
| II | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
<i>10</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Dec 1</i> 19 <i>45</i> to <i>Dec 19</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>Dec 18</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<i>Kennard Yaffe</i> | | 23B. DATE SIGNED
<i>12/20/65</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>KENNARD YAFFE</i> | | 23D. ADDRESS
<i>5501 Forest Park Ave</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>12/22/65</i> | |
| 24C. NAME OF CEMETERY OR CREMATORY
<i>Western</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore 23, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>DEC 21 1965</i> | | 25B. NAME OF REGISTRAR
<i>Witzke E. D.</i> | |
| 25C. FUNERAL DIRECTOR
<i>4101 Edmondson Ave</i> | | ADDRESS | |



1
H 250

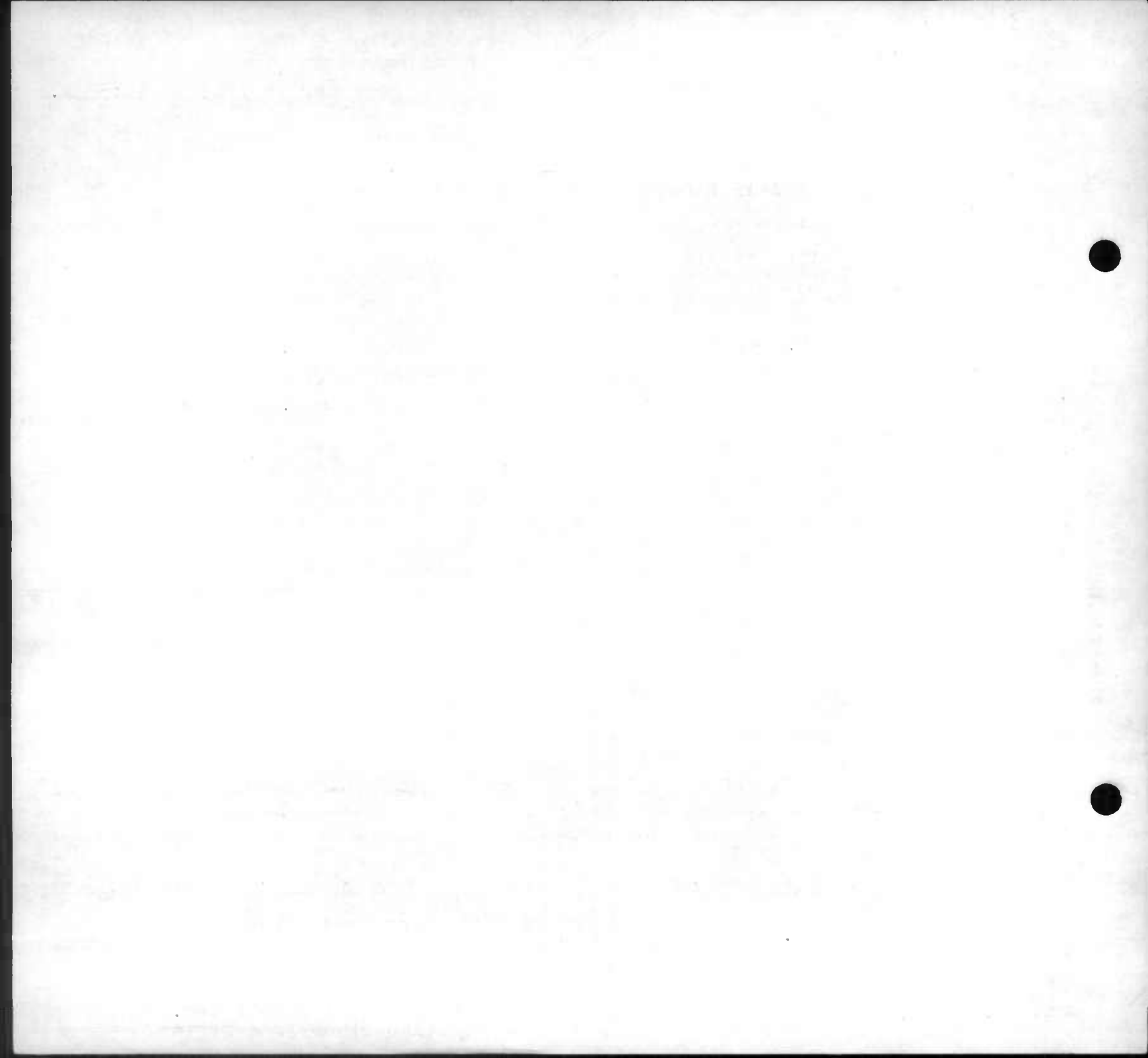
| | | | |
|---|---------|--|------------------|
| BIRTH NO. | | M.E. CASE NO. | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| CLAUDE S. HOGAN | | 12/18/65 10:20 a. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | |
| 509 N. Longwood St
Lutheran Hospital | | Maryland | |
| | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | |
| | | Baltimore 20-02 | |
| | | D. STREET ADDRESS (If rural, give location) | |
| | | 509 N. Longwood St. | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH |
| male | white | married | Nov. 7, 1897 |
| 9. AGE (In years last birthday) | | 10. BIRTHPLACE (State or foreign country) | |
| 68 | | Virginia | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| USA | | USA | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| late Christopher Hogan | | late Elizabeth --- | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| yes WW 1 | | | |
| 17. INFORMANT | | ADDRESS | |
| Mrs. Bertha Hogan, 509 N. Longwood St | | | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | |
| Arteriosclerotic cardiovascular disease | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 0 | | no | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| no | | | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | |
| | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| Werner U. Spitz, M.D. | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED | | | |
| 12/19/65 | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | |
| burial | | 12/22/65 | |
| 23C. NAME of CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| Western | | Balto. 23, Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | |
| DEC 21 1965 | | Robert E. Spitz | |
| 24C. FUNERAL DIRECTOR | | ADDRESS | |
| Witzke F.D. 4101 Edmondson Ave | | | |

— 1978 —

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 12975</u> | |
|---|-------------------------|--|---|---|--|
| BIRTH NO. <u>65 12975</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>HENRIETTA MORRISON McQUADE</u> | | 2. DATE AND HOUR OF DEATH
<u>December 19, 1965</u> <u>11:58 A.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY <u>8-05</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>House in the Pines</u>
<u>5837 Belair Road</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE 21213</u> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<u>1626 East Lafayette Avenue</u> | | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Widow</u> | 8. DATE OF BIRTH
<u>May 21, 1869</u> | 9. AGE (In years last birthday)
<u>96</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>at Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Harrisonburg Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 13. FATHER'S NAME
<u>John C. Morrison</u> | | 14. MOTHER'S MAIDEN NAME
<u>Henrietta H. Steierwald</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>none</u> | | 17. INFORMANT ADDRESS
<u>1626 East Lafayette Avenue</u>
<u>Miss Katherine M. McQuade</u> | |
| 18. <u>422.1</u> I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
<u>Anterior-sclerotic cardio-vascular disease</u> | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Nat White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>26 December 1958</u> to <u>19 December 1965</u> , that (I) was last saw the deceased alive on <u>26 November 1965</u> and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we (did) did not view the body after death. | | | | | |
| 23A. SIGNATURE
<u>John W. Barnaby</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>12/20/65</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>John W. Barnaby</u> | | 23D. ADDRESS
M.D. <u>1531 East North Avenue</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>12/21/65</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Woodlawn Cemetery</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State)
<u>Woodlawn Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>DEC 21 1965</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. ...</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>Henry Sander & Sons Inc.</u>
<u>Baltimore Maryland 21213</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12976 | |
|--|-------------------------|---|---|---|--|
| BIRTH NO. 65 12976 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) ANDREW SEBREE | | 2. DATE AND HOUR OF DEATH
12-19-65 9:15AM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 15-06 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION
THE JOHNS HOPKINS HOSPITAL | | D. STREET ADDRESS (If rural, give location)
2008 DUKELAND STREET | | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWER | 8. DATE OF BIRTH
June 9, 1904 | 9. AGE (In years last birthday)
61 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
CHARLES SEBREE | | 14. MOTHER'S MAIDEN NAME
REBECCA SELDON | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
212-03-7957 | | 17. INFORMANT ADDRESS
Oscar Sebree 2503 MOSHER ST. | |
| 18. 260X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) ?? MI
DUE TO
(B) Generalized atherosclerosis
DUE TO
(C) Diabetes mellitus | | INTERVAL BETWEEN ONSET AND DEATH
hrs
year
> 5 yrs | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Terminal seizure and aspiration | | | | | |
| 19A. DATE OF OPERATION
2-6 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Terminal seizure and aspiration | | 20A. AUTOPSY? (Yes or No)
yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
— | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)
NO | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
— | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
— | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/3 1965 to 12/19 1965 , that (I) (we) last saw the deceased alive on 12/19 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Robert I. Keimowitz M.D. | | 23B. DATE SIGNED
12/19/65 | | | |
| 23C. PHYSICIAN'S NAME (Type)
Robert I. Keimowitz M.D. | | 23D. ADDRESS
Johns Hopkins Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12/23/65 | | 24C. NAME of CEMETERY or CREMATORY
Arbutus Mem. Pk. | |
| 24D. LOCATION
Arbutus, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 21 1965 | | 25B. NAME OF REGISTRAR
Robert I. Keimowitz | | 25C. FUNERAL DIRECTOR ADDRESS
George C. Heller 1348 N. Calhoun St. | |

TO THE HONORABLE

MEMBER OF THE

HOUSE OF REPRESENTATIVES



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12977 | |
|---|---|--|--|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 65 12977 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) HUBERT JAMES PRELL, SR. | | 2. DATE AND HOUR OF DEATH
12-20-65 1:40 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

44 UNION Memorial Hospital | | A. STATE MD. | | | |
| | | B. COUNTY 12-06 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTO. | | | |
| | | D. STREET ADDRESS (If rural, give location)
118 W. 27TH Street. | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
7-28-85 | 9. AGE (In years last birthday)
80 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Chauffeur retired | | 10B. KIND OF BUSINESS OR INDUSTRY
American Can Co. | | 11. BIRTHPLACE (State or foreign country)
M.D. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 13. FATHER'S NAME
Baltagert Prell | | 14. MOTHER'S MAIDEN NAME
Elizabeth Kruppke | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No K. | | 16. SOCIAL SECURITY NO.
" | | 17. INFORMANT
Hubert J. Prell, Jr. | |
| | | | | ADDRESS
S.A.A. | |
| 18. 177X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) Ca of Prostate & metastasis
DUE TO | | (Years) | |
| | | (B) Asthma Generalized
DUE TO | | (Days) | |
| | | (C) chronic pyelonephritis
Bronchopneumonia, bilateral | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Fract. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12-18 1965 to 12-20 1965 .
that (I) (we) lost saw the deceased alive on 12-20 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Arthur M. LaBruce Jr. M.D. | | | | 23B. DATE SIGNED
12-20-65 | |
| 23C. PHYSICIAN'S NAME (Type)
ARTHUR M. LA BRUCE, JR. | | 23D. ADDRESS
UNION MEMORIAL HOSPITAL
UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12/23/65 | | 24C. NAME of CEMETERY or CREMATORY
Holy Redeemer | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 21 1965 | | 25B. NAME OF REGISTRAR
John A. Moran, Inc. | | 25C. FUNERAL DIRECTOR ADDRESS
3000 E. Balto. St | |

UNITED STATES OF AMERICA

DEPARTMENT OF JUSTICE

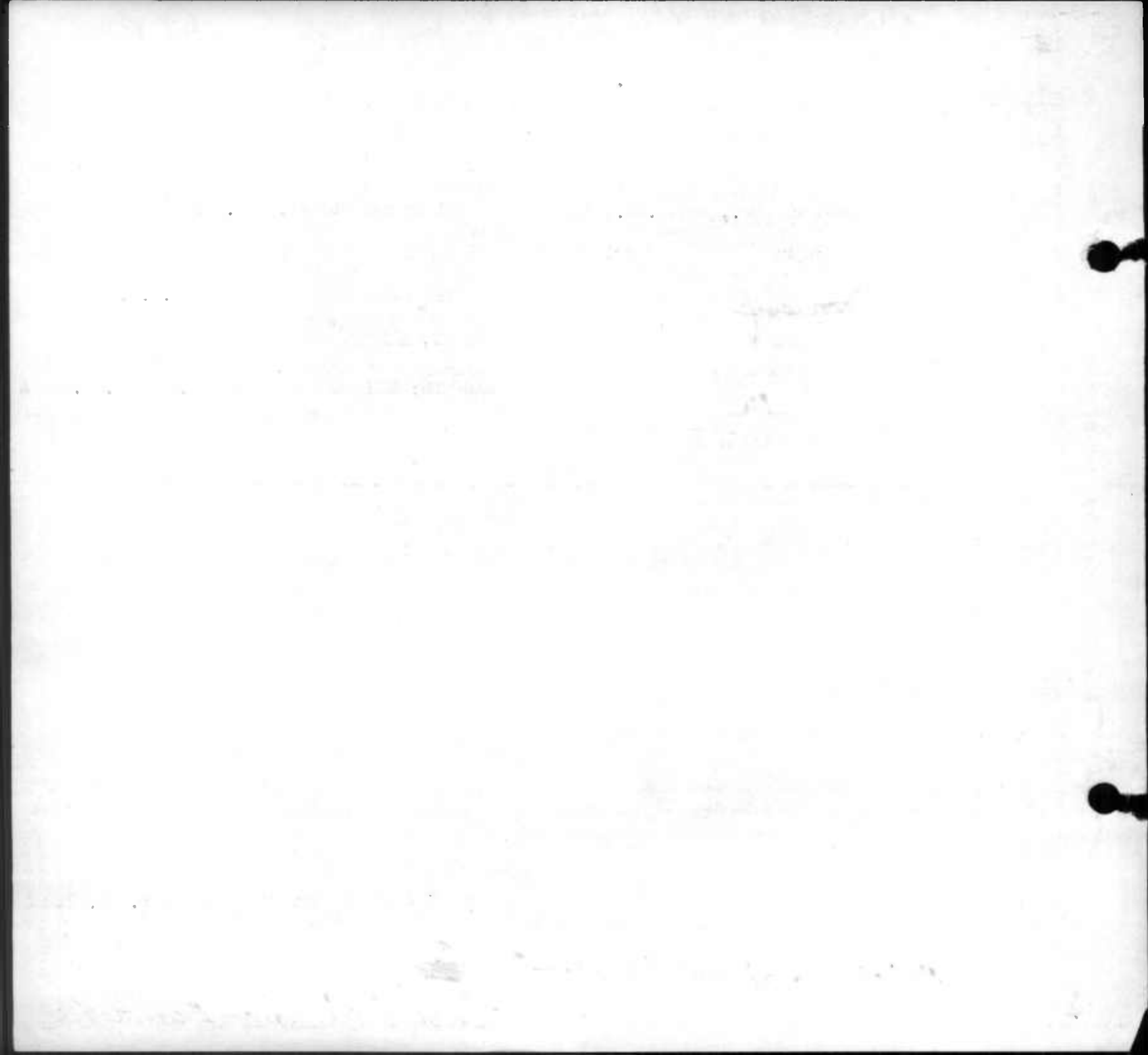
45-23-10
NIW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 12978 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 12978 | |
|---|-------------------------|---|--|--|--|
| M.E. CASE NO. 45-23-10 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Smith, Mary H.</u> | | | 2. DATE AND HOUR OF DEATH
<u>12-18-65</u> <u>2:05 a.m.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>Baltimore City Hospital</u>
<u>4940 Eastern Ave., Balto. Md., 21224</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY <u>17-03</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u>
D. STREET ADDRESS (If rural, give location)
<u>851 George Street, Apt. 6G 21201</u> | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>Negro</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>5/20/30</u> | 9. AGE (In years last birthday)
<u>35</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>VIRGINIA</u> | |
| 13. FATHER'S NAME
<u>LEVI BLACKWELL</u> | | | 14. MOTHER'S MAIDEN NAME
<u>SCOTT, ADA</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>RECORDS: BCH 4940 Eastern Ave., Balto. Md. 21224</u> | |
| 18. <u>153.8 - 012.0</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<u>Peritonitis</u> | | | CAUSE OF DEATH
(A) DUE TO
<u>Ca of Colon</u>
(B) DUE TO
<u>Head of Spine</u>
(C) <u>Tbc of the spine</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>unknown</u>
<u>one year</u>
<u>one year</u> |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>12-18-65</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Colonic fistula</u> | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>November 17 19 65</u> to <u>December 18 19 65</u> , that (I) (we) last saw the deceased alive on <u>December 18 19 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Oswaldo Quintero M.D.</u> | | | | 23B. DATE SIGNED
<u>12-18-65</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>OSVALDO Quintero</u> | | | 23D. ADDRESS
<u>4940 Eastern Avenue, Balto. Md. 21224</u>
<u>Baltimore City Hospital</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>12-21-65</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Baltimore City</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Md</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>DEC 21 1965</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Stachura</u> | |
| 25C. FUNERAL DIRECTOR
<u>Chas. C. Wilborn</u> | | 25D. ADDRESS
<u>Beanty Re</u> | | | |



65 12979

BALTIMORE CITY HEALTH DEPARTMENT

65 12979

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

EDWARD

G.

ROBINSON

2. DATE AND HOUR PRONOUNCED DEAD

December 16, 1965

10:40 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2242 Guilford Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2242 Guilford Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

12-28 1923

9. AGE (In years
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

George Robinson Sr

14. MOTHER'S MAIDEN NAME

Estelle Chapple

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Virginia Patrick 1031 Penna Ave

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/16/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12-20-65

23C. NAME OF CEMETERY or CREMATORY

Mt. Lakeview Cmt

23D. LOCATION

(City, town, or county)

(State)

Brooklyn Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 21 1965

24B. NAME OF REGISTRAR

Robert E. [Signature]

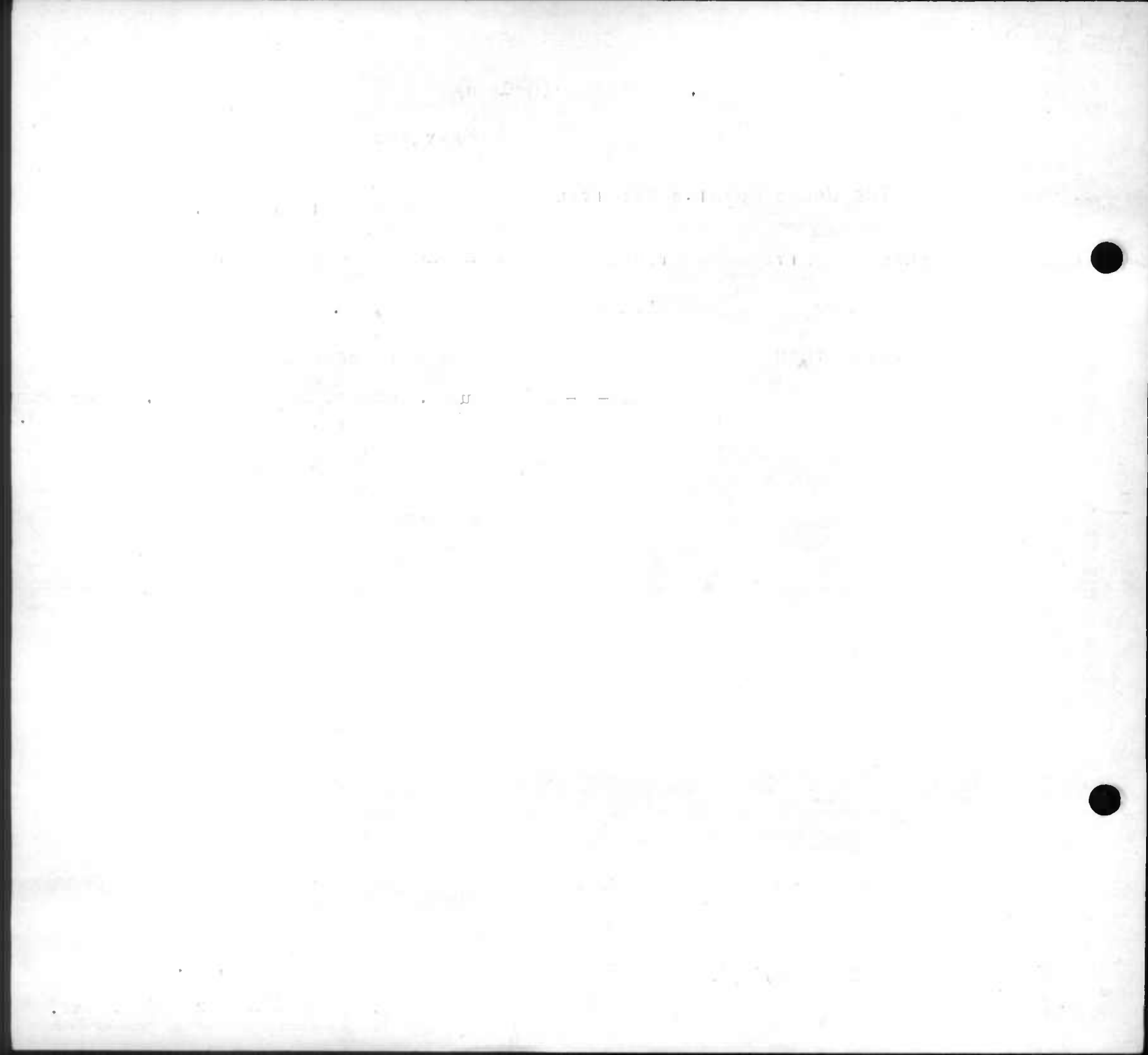
24C. FUNERAL DIRECTOR

Edgar [Signature]

ADDRESS

12 10 65
75 62 39
Poulsen, Margaret
Funeral Director: IMPORTANT
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

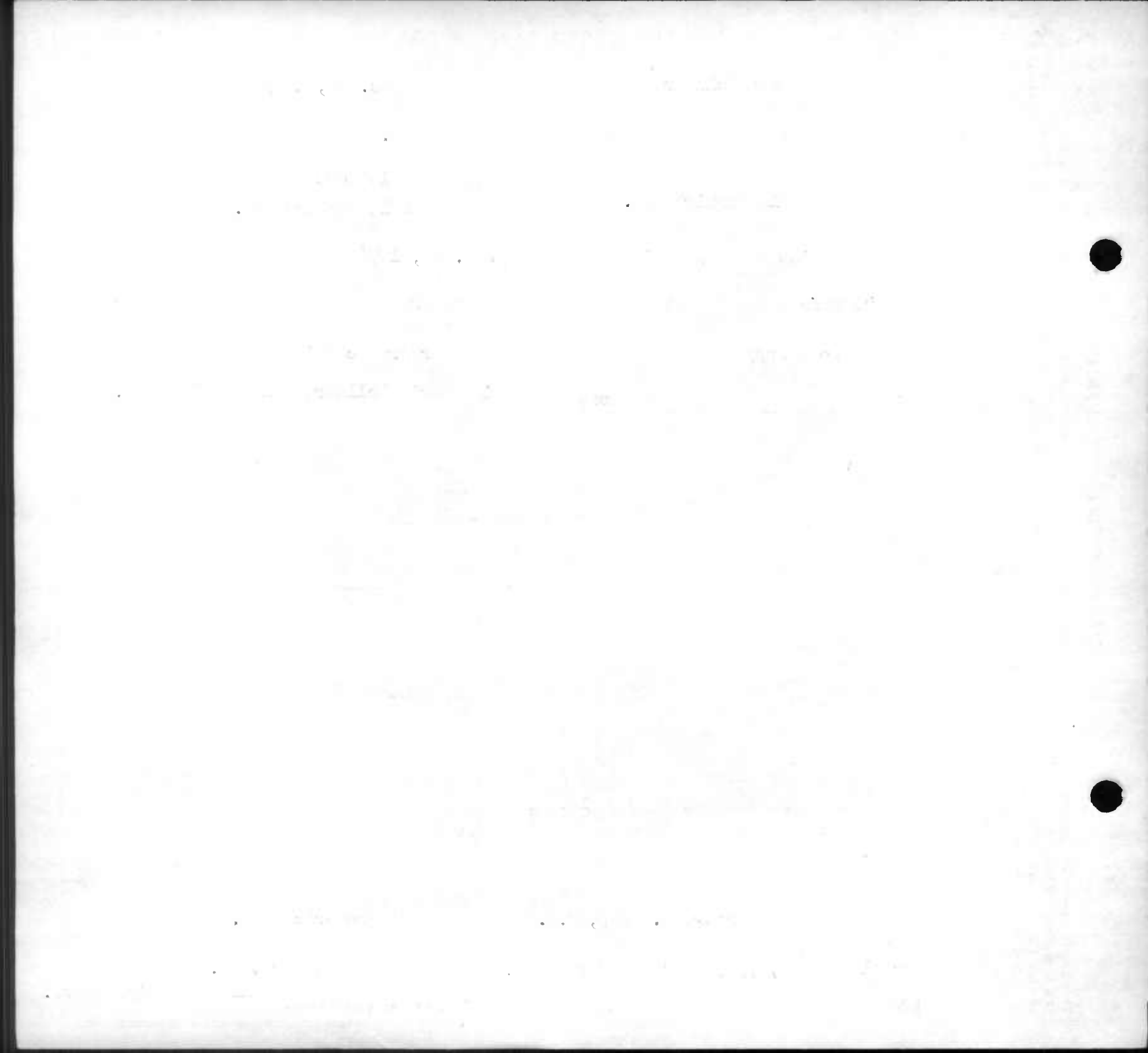
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12980 | |
|--|-------------------------|--|--|---|--|
| BIRTH NO. 65 12980 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) <u>Margaret M. Poulsen (Poulsen)</u> | | | | 12/18/65 9 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY <u>27-16</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>THE JOHNS HOPKINS HOSPITAL</u> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> | |
| | | | | D. STREET ADDRESS (If rural, give location)
<u>4749 PARK HEIGHTS AVE.</u> | |
| 5. SEX
<u>FEMALE</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>WIDOWED</u> | 8. DATE OF BIRTH
<u>1-27-04</u> | 9. AGE (In years last birthday)
<u>61</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Packer</u> | | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME
<u>ARTHUR STERN</u> | | | 14. MOTHER'S MAIDEN NAME
<u>MARGARET HOFFMAN</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | | 16. SOCIAL SECURITY NO.
<u>218-09-5286</u> | | 17. INFORMANT ADDRESS
<u>Paul A. Poulsen, 220 Chartley Dr. Reisterstown Md.</u> |
| 18. <u>2000 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>CAUSE OF DEATH</u>
(A) <u>Sepsis, hemorrhage</u>
DUE TO
(B) <u>Diffuse Retic. cell Sa.</u>
DUE TO
(C) _____
INTERVAL BETWEEN ONSET AND DEATH
<u>2 da.</u>
<u>? 6 mos.</u> | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Nat While <input type="checkbox"/> At Work | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/4/65</u> 19 <u>65</u> to <u>12/18</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12/18/65</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Wesley T. Haase</u> | | | | 23B. DATE SIGNED
<u>12/18/65</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Wesley T. Haase</u> | | | | 23D. ADDRESS
<u>JOHNS HOPKINS HOSPITAL</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>12/22/65</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Loudon Park Cemetery</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>DEC 21 1965</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. [unclear]</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>4611 Park Heights Ave.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 12981</u> | |
|--|-------------------------|--|--|---|--|
| BIRTH NO. <u>65 12981</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Rosa Vollmer</u> | | 2. DATE AND HOUR OF DEATH
<u>Dec. 20, 1965</u> <u>4 30</u> <u>A</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Md.</u>
B. COUNTY <u>28-04</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
<u>4712 Dunkirk Ave.</u> | | D. STREET ADDRESS (If rural, give location)
<u>4712 Dunkirk Ave.</u> | | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Widow</u> | 8. DATE OF BIRTH
<u>Jan. 24, 1876</u> | 9. AGE (In years
last birthday)
<u>89</u> | If Under 1 Yr. Months: Days: Hours: Min.
If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>At Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Hungary</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>Hungary</u> | | 13. FATHER'S NAME
<u>John Hupp</u> | | 14. MOTHER'S MAIDEN NAME
<u>Barbara Schneider</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
<u>Miss Maria Vollmer, 4712 Dunkirk Ave.</u> | |
| 18. <u>420.11</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
<u>CAROTID OCCLUSION</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.
<u>H.C.V.D.</u> | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
<u>10 YRS.</u> | |
| MEDICAL CERTIFICATION | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>II</u> | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4/28/59</u> 19 to <u>12/20/65</u> 19, that (I) (we) last saw the deceased alive on <u>12/20/65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Herbert W. Lapp</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>12/21/65</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Herbert W. Lapp, M.D.</u> | | 23D. ADDRESS
<u>4804 Frederick Ave.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>12/23/65</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Loudon Park Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>DEC 21 1965</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. [unclear]</u> | | 25C. FUNERAL DIRECTOR
<u>E. [unclear]</u> | | 25D. ADDRESS
<u>4611 Park Heights Ave.</u> | |

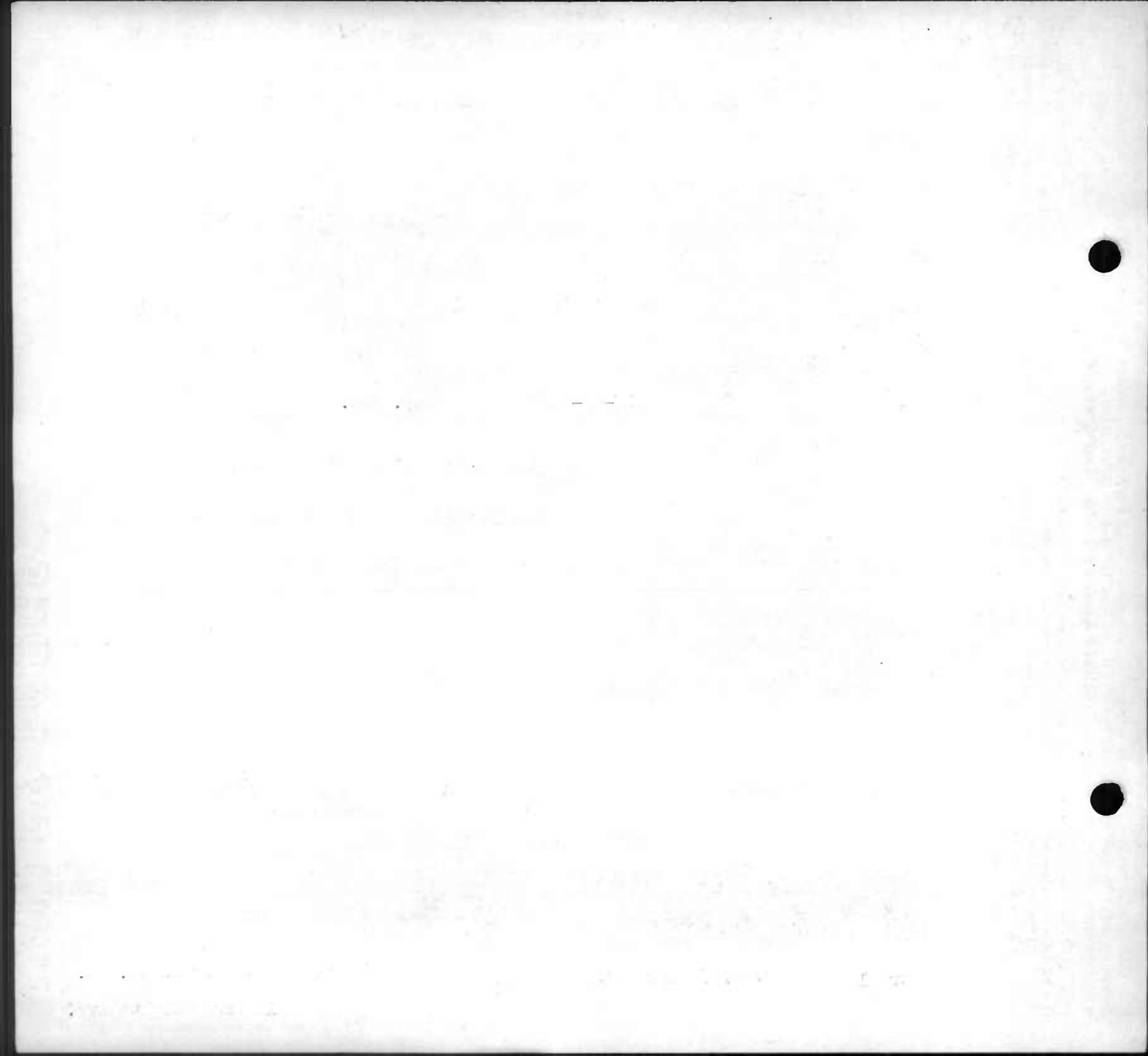


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|---|---|--|---|
| BIRTH NO.
65 12982 | | BALTIMORE CITY HEALTH DEPT.
CERTIFICATE OF DEATH | | Registered No. 65 12982 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) <i>Lanciotti, Lucy T.</i> | | 2. DATE AND HOUR OF DEATH
<i>12/20/65</i> <i>9:50 a.m.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

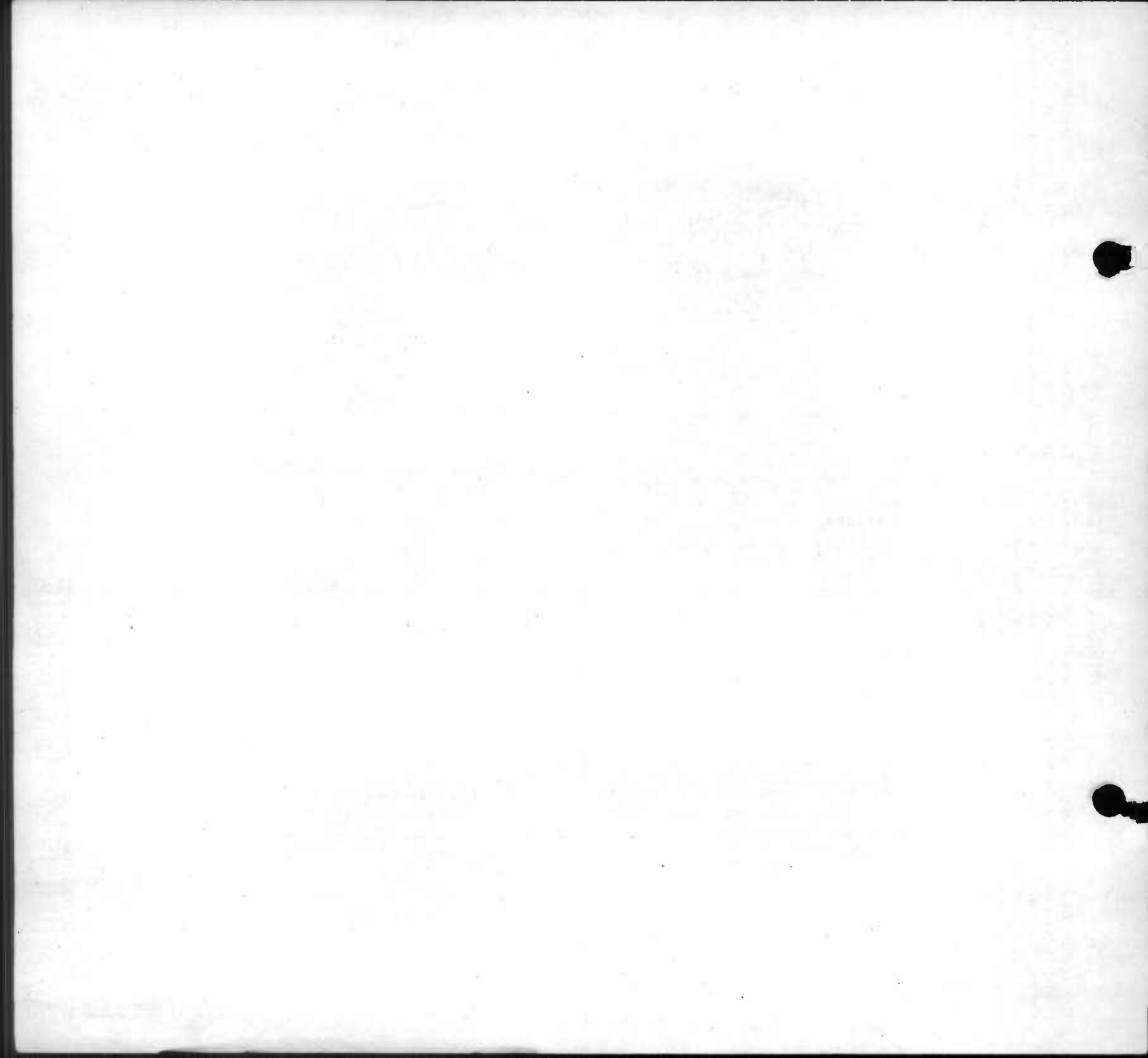
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>Maryland General Hospital</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Md.</i> B. COUNTY <i>Balto</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Balto Laurel Drive 5300</i>
D. STREET ADDRESS (If rural, give location)
<i>6723 Laurel Drive</i> | | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>Married</i> | 8. DATE OF BIRTH
<i>6/13 1901</i> | 9. AGE (In years last birthday)
<i>64</i> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Tailor</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Tailor</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Mens Clothing</i> | 11. BIRTHPLACE (State or foreign country)
<i>Italy</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>Italy</i> |
| 13. FATHER'S NAME
<i>Andrew Turlli</i> | | | 14. MOTHER'S MAIDEN NAME
<i>Joseine Fabiana</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>217-03-0268</i> | | 17. INFORMANT
<i>Hosp. Rec.</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<i>General metastases</i>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.
<i>Carcinoma, right breast</i> | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| MEDICAL CERTIFICATION
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<i>II</i> | | | | | |
| 19A. DATE OF OPERATION
<i>10/19/65 (Lupus)</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Ac. cholecystitis</i> | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Nov 23rd</i> 19 <i>65</i> to <i>Dec 17th</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Chg. J. Thorsteinsson</i> M.D. | | | | 23B. DATE SIGNED
<i>12/20/65</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Vigil Thor Thorsteinsson</i> | | | | 23D. ADDRESS
<i>903 Nottingham Rd 1B Balto 29 Md.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>12/24/65</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>Lake View Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Liberty Road, Carroll Co. Md.</i> | | 25A. DATE RECEIVED BY HEALTH DEPT.
<i>DEC 21 1965</i> | | | |
| 25B. NAME OF REGISTRAR
<i>Robert E. ...</i> | | 25C. FUNERAL DIRECTOR
<i>Veron ...</i> | | ADDRESS
<i>4611 Park Heights Ave.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|---|------------------------------------|--|--|
| BIRTH NO. 65 12983 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 65 12983 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) DANIEL OLIVER SPENCE | | 2. DATE AND HOUR OF DEATH
Dec. 20, 1965 5:15 p.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission)
A. STATE Maryland B. COUNTY 15-09 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
3912 Duval Ave. Baltimore, Md. | | D. STREET ADDRESS (If rural, give location)
3912 Duval Ave. | | | |
| 5. SEX M | 6. RACE N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
3/18/19 | 9. AGE (In years last birthday)
46 | 10. If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Post office clerk | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Ollie Spence | | 14. MOTHER'S MAIDEN NAME
Matie Wallace | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
yes | | 16. SOCIAL SECURITY NO.
218-01-4672 | | 17. INFORMANT
John Colbert (brother) ADDRESS 3211 Carlisle | |
| 18. 163 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Lung Cancer | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
Unknown | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(note: discharged from VAMH Loch Raven 12/12/65) | | (B) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from I never saw patient before 19 7 that (I) (we) last saw the deceased alive on 12/12/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. seen this morning by Dr. Belcher | | 23A. SIGNATURE
D. W. Stewart M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> 12/20/65 | |
| 23B. PHYSICIAN'S NAME (Type)
D. W. STEWART M.D. | | 23C. ADDRESS
3414 Duval Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12/24/65 | | 24C. NAME OF CEMETERY OR CREMATORY
Barto National | |
| 24D. LOCATION (City, town, or county) (State)
Barto Md | | 25A. DATE REC'D BY HEALTH DEPT.
DEC 21 1965 | | 25B. NAME OF REGISTRAR
Dr. J. E. Johnson | |
| 25C. FUNERAL DIRECTOR
Marshall Rogers | | ADDRESS
38 N. Baltimore | | | |



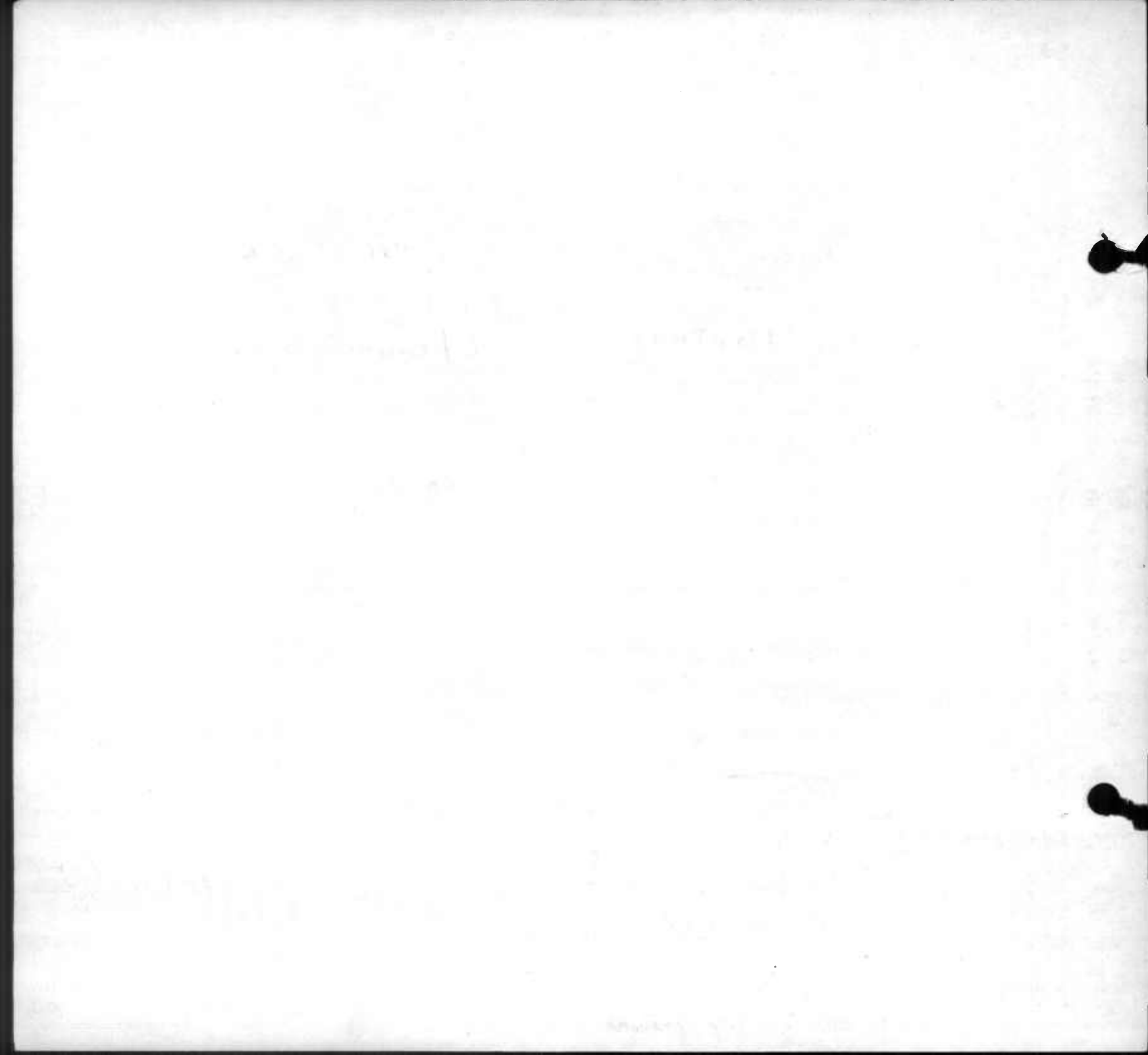
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 12984 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 12984 | |
|--|--|--|--|--|--|---|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) Louis M. Colon | | 2. DATE AND HOUR OF DEATH
12/17/65 4:45 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE Md
B. COUNTY 17-01 | | 5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
38 University Hospital | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | D. STREET ADDRESS (If rural, give location)
900 Argyle Ave. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laos | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH
3/26/1911 | | 9. AGE (In years last birthday) 54 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 11. BIRTHPLACE (State or foreign country)
Puerto Rico | | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
tele Faro Martinez | | | |
| 14. MOTHER'S MAIDEN NAME
Chemeistina Colon | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Adessa Colon 900 Argyle Ave Apt 6F | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Disseminated Bronchogenic Carcinoma | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO | | (B) DUE TO | | | |
| (C) DUE TO | | | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/19/65 to 12/17/65 , that (I) (we) last saw the deceased alive on 12/17/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Jonathan Tuerc | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
12/12/65 | | | |
| 23C. PHYSICIAN'S NAME (Type)
JONATHAN TUERC | | | | M.D. | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12/21/65 | | 24C. NAME OF CEMETERY or CREMATORY
Mt Auburn | | 24D. LOCATION (City, town, or county) (State)
Baltimore | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR
James P. Hughes | | ADDRESS
638 N. Baltimore St | | | |

DEC 21 1965

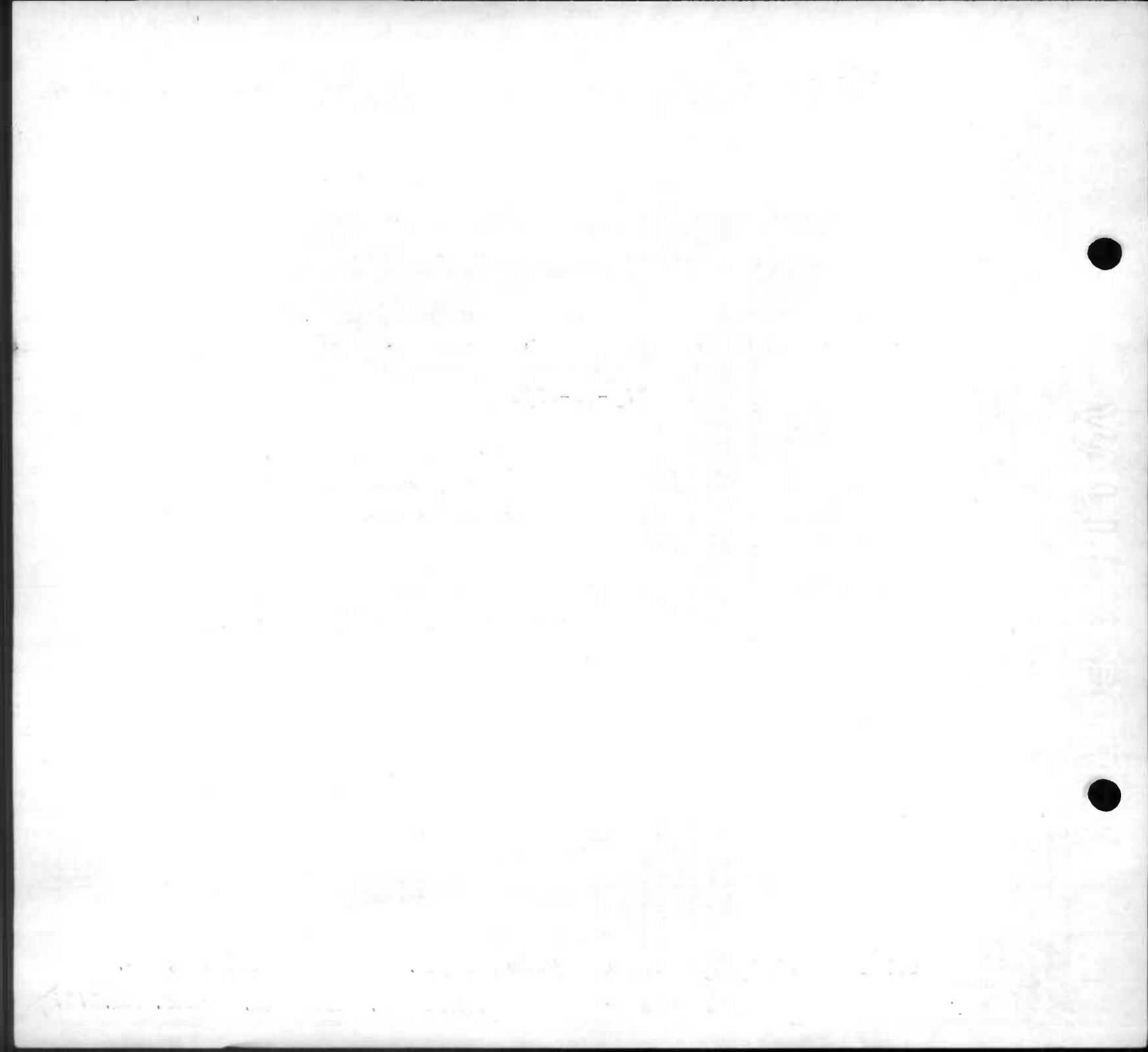
DEC 22 1965



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

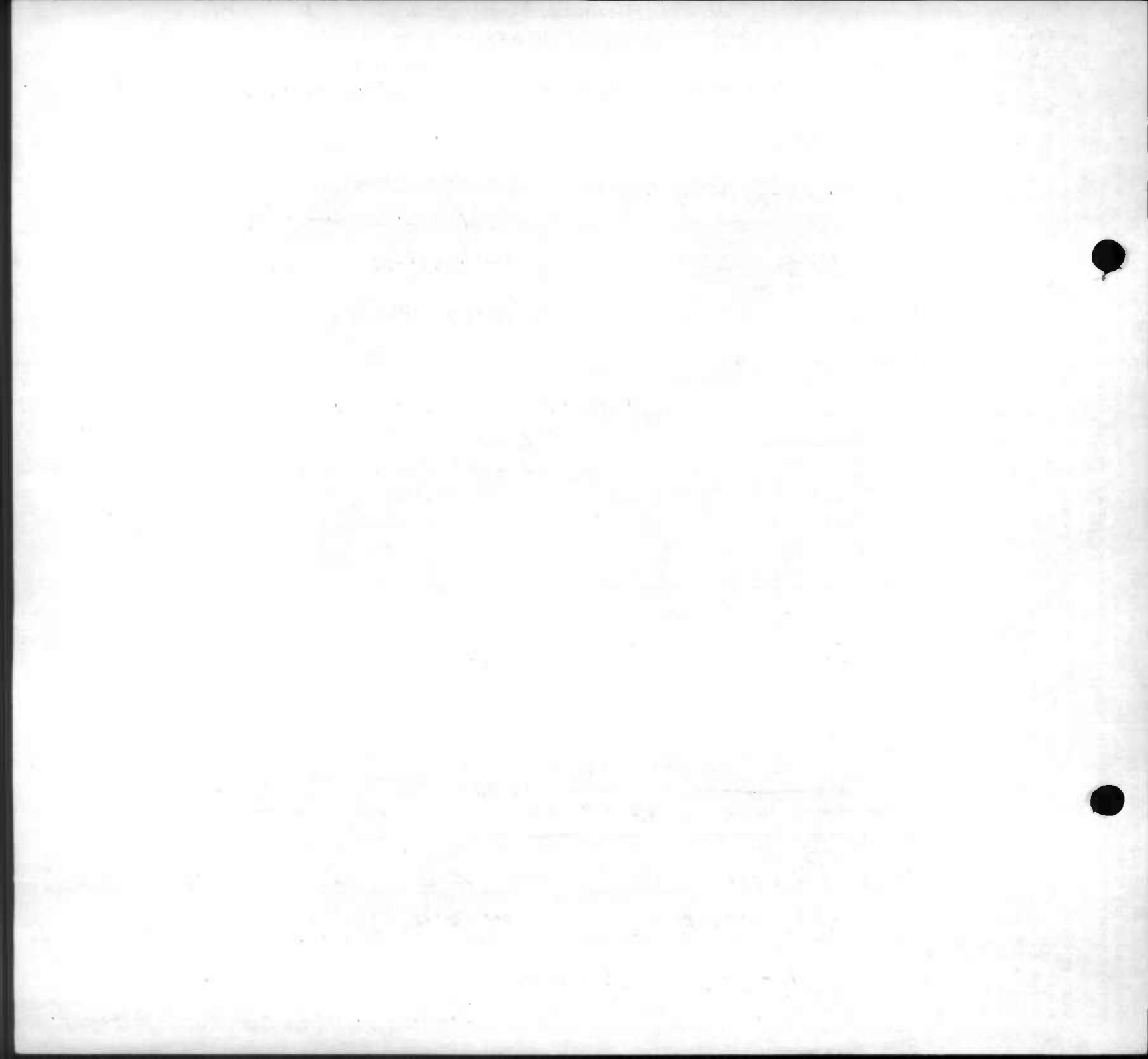
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12985 | |
|--|--|--|--------------------------------------|--|--|
| BIRTH NO.
65 12985 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) MARY K. KEENAN | | 2. DATE AND HOUR OF DEATH
12/20/1965 15:40 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 26-01 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
48 Maryland General Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location)
5904 Willet Ave. | | | |
| 5. SEX
Female | 6. RACE
Cauc | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widow | 8. DATE OF BIRTH
4/27/1894 | 9. AGE (In years last birthday)
71 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore | |
| 13. FATHER'S NAME
Michael J. Kearney | | 14. MOTHER'S MAIDEN NAME
Hannah Keiley | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-46-6176 | | 17. INFORMANT
Hosp. Chart ADDRESS | |
| 18. 1330 I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Enterocolitis - hemorrhagic + pseudomembranous megacolon | | (A) DUE TO | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II | | Carcinoma of cecum | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
12/16/64 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Carcinoma of Ventral Perineal Coecum | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/14/65 1965 to 12/20/ 1965, that (I) (we) last saw the deceased alive on 12/20/ 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
H. L. Marler | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
12/20/1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
582 9th Maryland General Hospital Baltimore | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
12/23/65 | 24C. NAME OF CEMETERY OR CREMATORY
Baltimore National Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 21 1965 | 25B. NAME OF REGISTRAR
Robert E. Taylor | 25C. FUNERAL DIRECTOR
Leonard J. Ruck Inc. Balto. Md. | | ADDRESS
21214 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

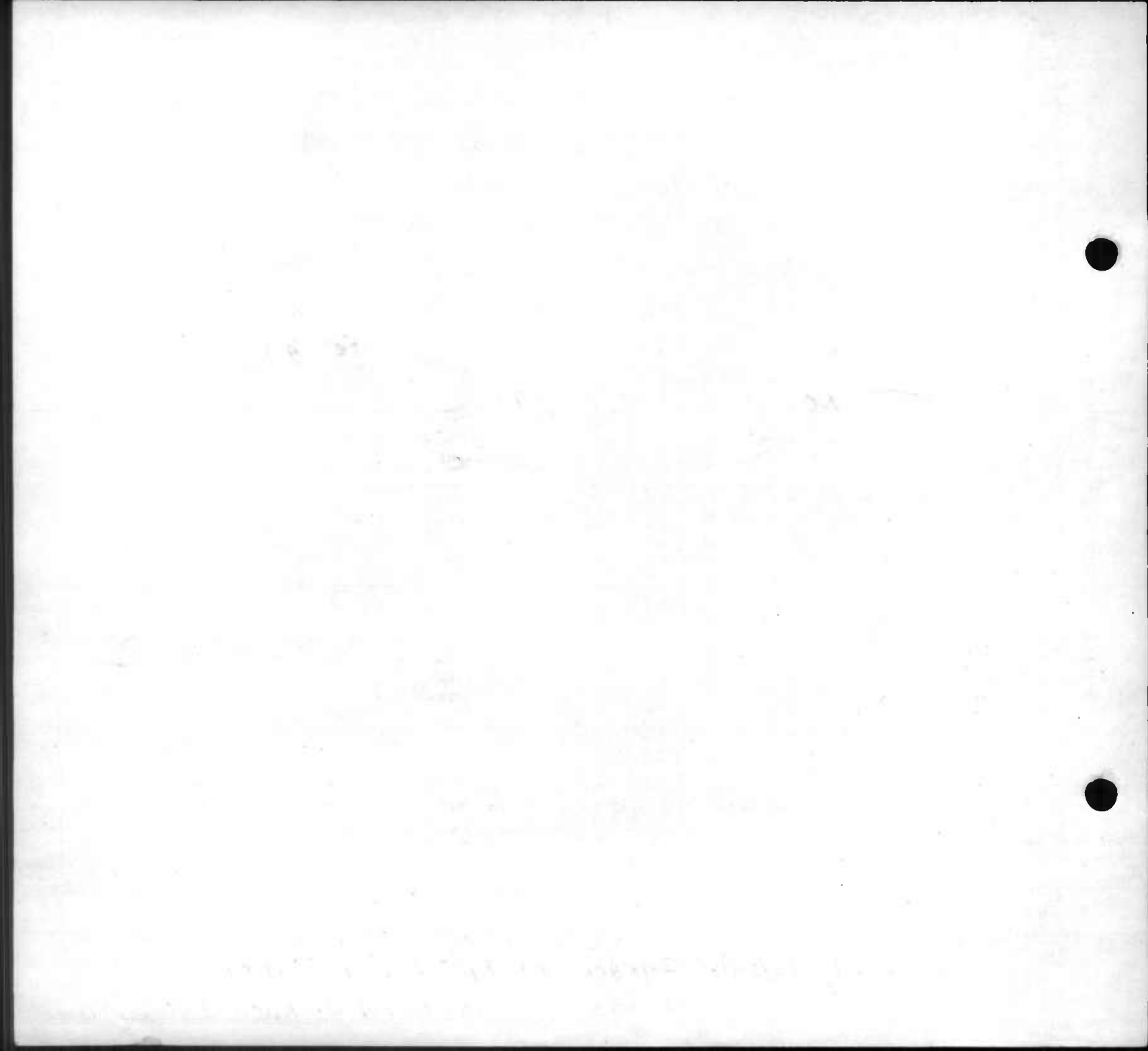
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12986 | |
|--|---------------|--|-------------------------------|--|--|
| BIRTH NO. 65 12986 | | CERTIFICATE OF DEATH | | Registered No. 65 12986 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Agnes Louise Meredith | | 2. DATE AND HOUR OF DEATH
Dec. 20, 1965 12 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md. B. COUNTY 27-02 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
00 2700 E. Cold Spring Lane | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location)
2700 E. Cold Spring Lane | | | |
| 5. SEX female | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed | 8. DATE OF BIRTH Nov. 4, 1873 | 9. AGE (In years last birthday) 92 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Michael Birmingham | | 14. MOTHER'S MAIDEN NAME Catherine Logue | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 212037190 | | 17. INFORMANT Miss Grace L. Meredith | |
| 18. 442X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH Arteriosclerotic cardio-vascular renal disease | | INTERVAL BETWEEN ONSET AND DEATH 3-5 years | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | (C) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1934 to 12-20-1965, that (I) (we) last saw the deceased alive on 12-13-45 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE G.W. Peake | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 12-21-65 | |
| 23C. PHYSICIAN'S NAME (Type) G.W. PEAKE | | 23D. ADDRESS M.D. 4508 Harford Road Balto 14 Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 12-23-65 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery | |
| | | | | 24D. LOCATION Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 21 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|---------|--|---|--|---|
| BIRTH NO. | | 65 12987 | | 65 12987 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| ALEXANDER L. LEONARD | | | 12/20/65 8 ³⁰ P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | A. STATE
B. COUNTY | | |
| MARYLAND GENERAL HOSPITAL | | | MARYLAND | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| | | | BALTIMORE | | |
| | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | 1927 WOODBOURNE AVE | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years
last birthday) | If Under 1 Yr.
Months Days |
| M | W | MARRIED | 2/19/15 | 50 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| SALESMAN | | SEALTEST FOODS | | MARYLAND | USA |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| IRA F. LEONARD | | | HENRIETTA (WALLY) WOLFE | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| UNKNOWN NO | | 29-20-5770 | | PATIENT | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
| 1979 I | | | LIPOMA | | 6 months |
| ANTECEDENT CAUSES | | | (A) DUE TO | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO | | |
| | | | (C) DUE TO | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSE OF DEATH? |
| 2 | | | | YES | YES |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/27/1965 to 12/20/1965, that (I) (we) last saw the deceased alive on 12/20/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| [Signature] | | | | 12/20/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| | | | Maryland General Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 12/24/65 | | GARDENS OF FAITH | |
| | | | | BALTIMORE MD | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| DEC 21 1965 | | [Signature] | | LEONARD J. RUCK, INC. | |
| | | | | BALTIMORE MD | |



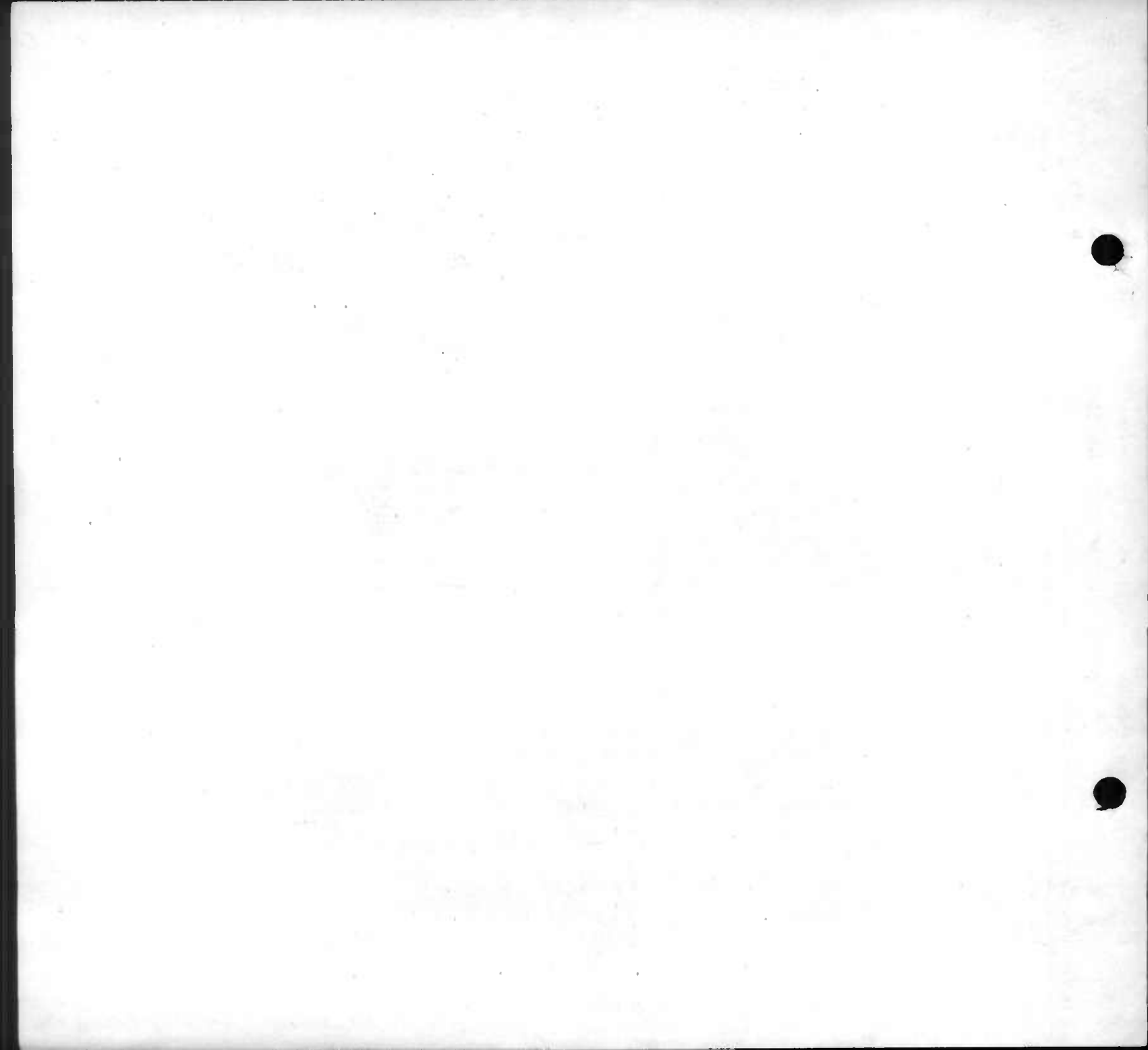
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12988 | |
|---|-----------|---|--|---|----------------------------------|
| BIRTH NO. 12988 | | M.E. CASE NO. 12988 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) MARY STEWART | | | 2. DATE AND HOUR OF DEATH 12-20-65 12:30 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MARYLAND B. COUNTY ANNAPOLIS | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME + HOSPITAL | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) ANNAPOLIS BALTIMORE | | |
| D. STREET ADDRESS (If rural, give location) GOULD NURSING HOME | | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 3-11-93 | 9. AGE (In years last birthday) 72 | 10. CITIZEN OF WHAT COUNTRY? USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary (Retired) | | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | |
| 13. FATHER'S NAME EDGAR SUIT | | | 14. MOTHER'S MAIDEN NAME DELIA KELLY | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 2-7-14 9816 | | |
| 17. INFORMANT CHART | | | ADDRESS @ | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) PULMONARY EMBOLUS - HOURS (B) FRACTURE RT. HUMERUS - DAYS | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELLITUS, Atherosclerotic Heart Disease | | | | | |
| 19A. DATE OF OPERATION 12/8/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED OPEN REDUCTION WITH INSERTION OF SCREW | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) CONVALESCARIUM | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 6116 Belair Rd 27-34 | |
| 21D. TIME OF INJURY (APPROX.) 11 24 65 7:05 AM | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? fell from bed | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE M. A. P. M.D. | | | | 23B. DATE SIGNED 12/20/65 | |
| 23C. PHYSICIAN'S NAME (Type) MARIANO A. ROLANTINO | | | | 23D. ADDRESS CHURCH HOME + HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 12/22/65 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery | |
| 24D. LOCATION (City, town, or county) Baltimore, Md. | | 24E. STATE (State) Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. DEC 21 1965 | | 25B. NAME OF REGISTRAR Robert J. Ruck Inc. | | 25C. FUNERAL DIRECTOR ADDRESS 21214 | |

SECRET

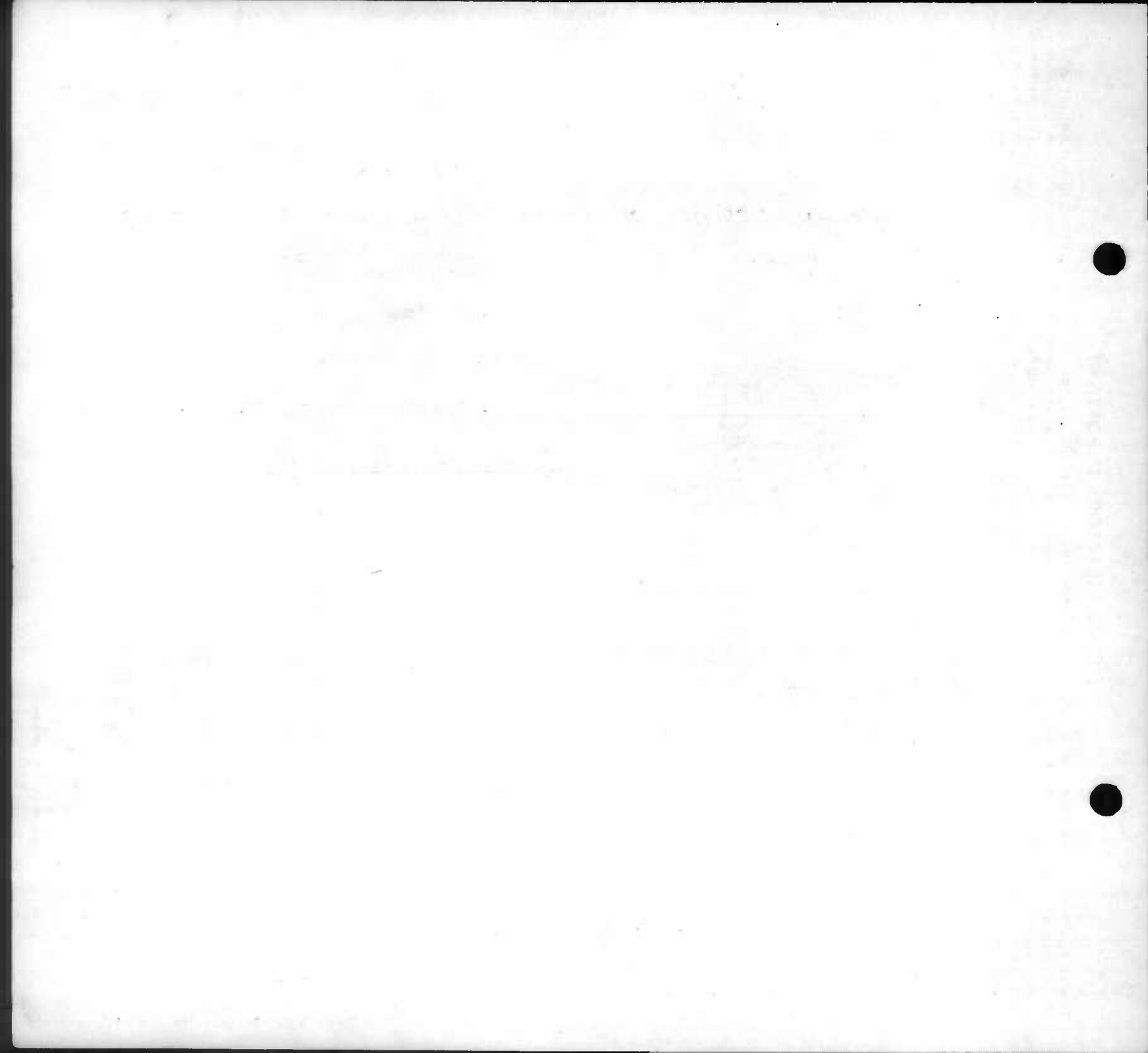
CONFIDENTIAL



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 65 12990 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 12990 | |
|--|-------------------------|---|--------------------------------------|--|----------------------------|---|-----------------------------|----------------------------------|--|
| 1. NAME OF DECEASED
(Type or Print) MINIE HOLMES | | | | 2. DATE AND HOUR OF DEATH
12/14/65 6:35 A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY 20-02 | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
LUTHERAN HOSPITAL OF MARYLAND | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE CITY | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
LUTHERAN HOSPITAL OF MARYLAND | | | | D. STREET ADDRESS (If rural, give location)
3139 W. LEXINGTON STREET | | | | | |
| 5. SEX
F | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
4/22/1891 | 9. AGE (In years last birthday)
74 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House Wife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
William Glenn | | | | 14. MOTHER'S MAIDEN NAME
Eusibia Doswell | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Mr. Sherlock Holmes 2139 W. Lexington | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
443X r 260X
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH
(A) Cerebral Thrombosis / Hemorrhage 4 mos
DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) Hypertensive Arteriosclerosis CVD 3-4 yrs
DUE TO | | | | | |
| | | | | (C) Cerebral Arteriosclerosis | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Diabetes Mellitus | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov. 10 19 65 to December 17 19 65 , that (I) (we) last saw the deceased alive on December 17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Florahaida S. Peroma | | | | M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
12/14/65 | | | |
| 23C. PHYSICIAN'S NAME (Type)
Florahaida S. Peroma | | | | 23D. ADDRESS
LUTHERAN HOSPITAL OF MARYLAND | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12/20/65 | | 24C. NAME OF CEMETERY or CREMATORY
Meherrin, Virginia | | 24D. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 21 1965 | | 25B. NAME OF REGISTRAR
Robert E. ... | | 25C. FUNERAL DIRECTOR
Wm G March | | ADDRESS
928 E. North Ave. | | | |



1

65 12991

BALTIMORE CITY HEALTH DEPARTMENT

65 12991

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES A. CHERRY

2. DATE AND HOUR PRONOUNCED DEAD

12/19/65 2:17 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2612 Lewellen Ave.

Lewellyn

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

April 8, 1943

9. AGE (In years
last birthday)

22

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James C. Cherry

14. MOTHER'S MAIDEN NAME

Corrie Freeman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Maudel Cherry 1323 Montford Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of face (lower lip)
DUE TO involving spinal cord

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN IDENTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

car

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

in car on N. Charles St.

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

12 19 65 about 2:00 a. m.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

shot in face

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/19/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/23/65

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION (City, town, or county)

Weldon, N.C.

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 21 1965

24B. NAME OF REGISTRAR

R. L. F. F. F.

24C. FUNERAL DIRECTOR

ADDRESS

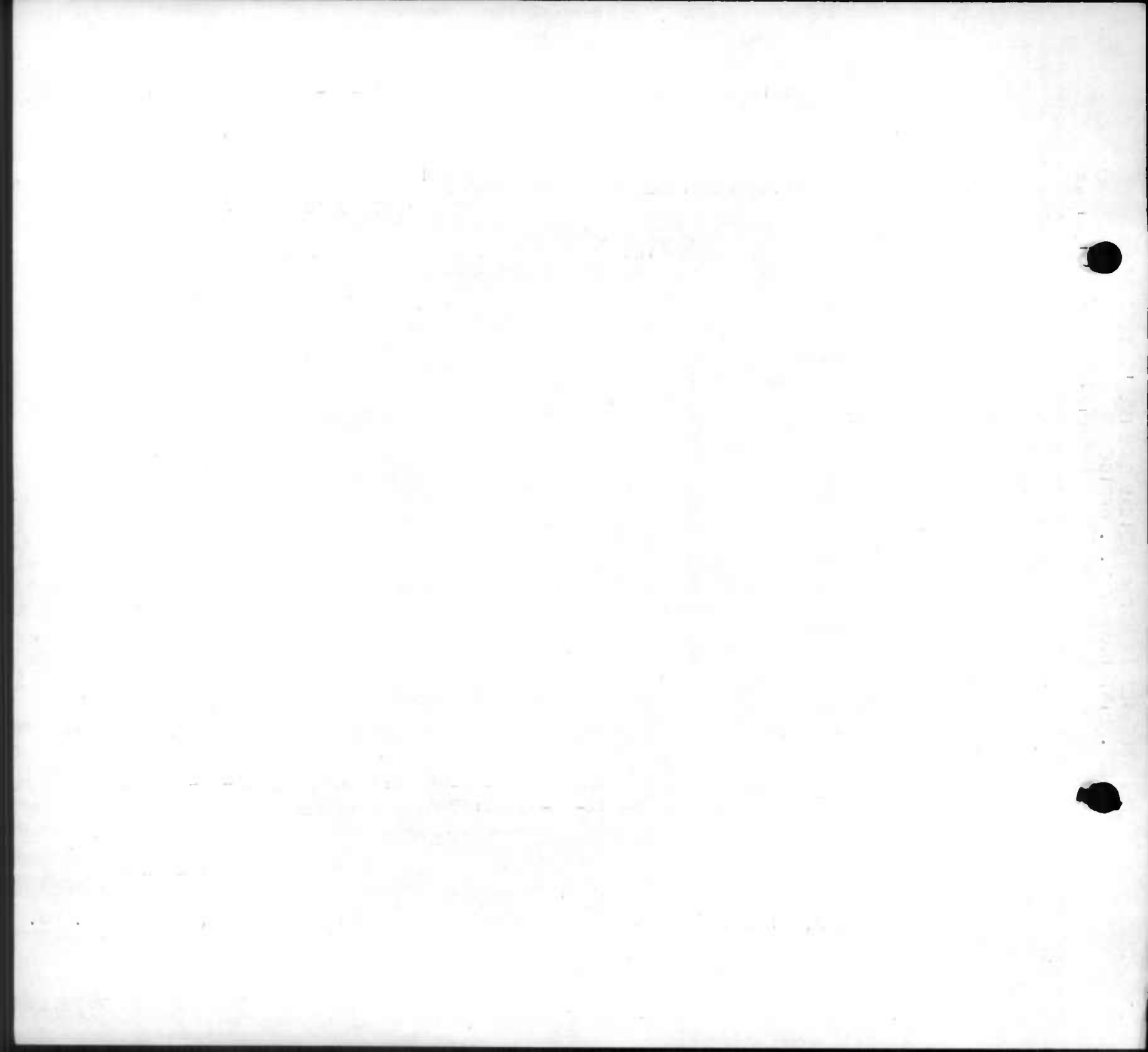
W.M.C. MARCH 928 E. North Ave

Unit Block of E. North Ave

RELEASED AS NOT A MEDICAL EXAMINER'S CASE BY
DR. LINTHICUM OF M.E. OFFICE
FUNERAL DIRECTOR: IMPORTANT
REASON FOR OF ADMISSIONS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|---------|--|--------------------------|---|-------------------------------------|
| BIRTH NO. | | 65 12992 | | 65 12992 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| NANNIE BRATCHER | | 12-19-65 8:45AM M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
THE JOHNS HOPKINS HOSPITAL | | A. STATE
MARYLAND | | | |
| | | B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 1322 NORTH BOND STREET | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years
last birthday) | 10. Under 1 Yr.
Months: Days |
| F | N | MARRIED | Sept 20, 1923 | 42 | |
| 10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | | | N.C. | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| DAVE BROOKS | | | Addie McCray | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | 214-36-9104 | | Eudie Bratcher 1322 N. Bond St. | |
| 18. 434.1 I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.) | | CAUSE OF DEATH | | | INTERVAL BETWEEN
ONSET AND DEATH |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last. | | (A) Cardiac Arrest -
DUE TO
Dr. had CHF and
(B) Presumably Asthma
DUE TO
(C) | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.) | | 21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME
OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While
At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-19-65 8:10 AM to 12-19-65 8:45AM
that (I) (we) last saw the deceased alive on 8-12-19-65 8:35AM and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Lee J. Silver | | | | 23B. DATE SIGNED
12-19-65 | |
| 23C. PHYSICIAN'S
NAME (Type)
LEE J. SILVER | | | | 23D. ADDRESS
THE JOHNS HOPKINS HOSPITAL, BALTIMORE, MD. | |
| 24A. BURIAL CREMATION,
REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 12/23/65 | | Balto National Cem. | |
| | | | | Balto, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| DEC 21 1965 | | R. J. [unclear] | | Wm C March 928 E. North Ave | |



BIRTH NO.

65 12993

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 12993

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DONALD

MARTIN

2. DATE AND HOUR PRONOUNCED DEAD

12-19-65

4:55 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

828 E. 22nd Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Aug. 26, 1951

9. AGE (In years
last birthday)

14

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Nathaniel Martin

14. MOTHER'S MAIDEN NAME

Berthe Wooten

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Berthe Fowlkes 828 E. 22nd St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) _____
DUE TO

Gunshot wound of head

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

828 E. 22nd Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
12 19 '65 4:00 PM

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot in head by 16 yr.

old brother

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

12-20-65

EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

12/23/65

23C. NAME of CEMETERY or CREMATORY

Auburn Mem. Park

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 21 1965

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

WM MARCH 928 E. North Ave

WALLLEY FORD

MADE IN U.S.A.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

White - per Telephone call to Hospital 12-23-65

Qm

12-18-62

12-18-62

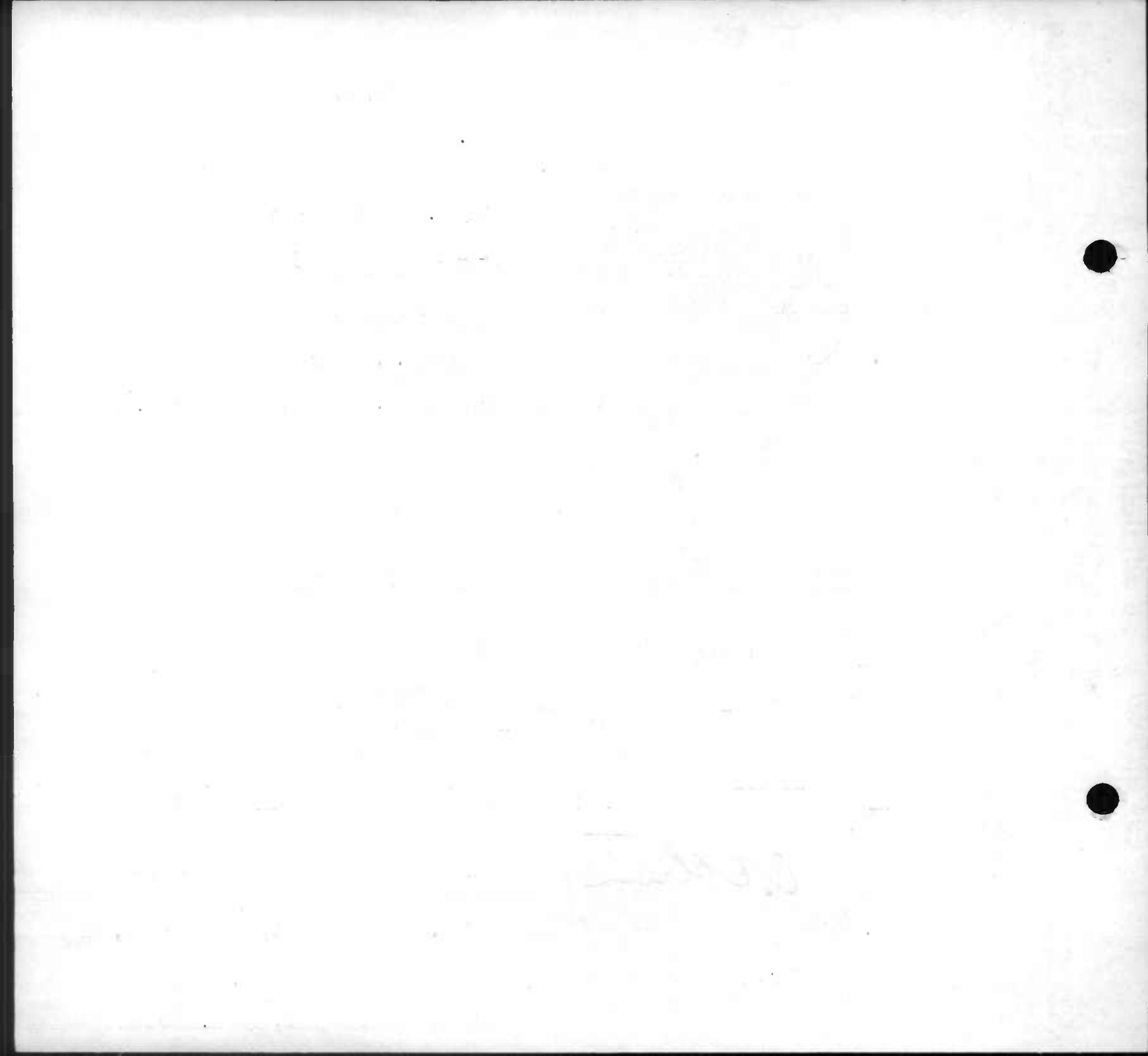
W

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|-------------------------|---|--|--|---|
| 65 12995 | | CERTIFICATE OF DEATH | | 65 12995 | |
| 1. NAME OF DECEASED
(Type or Print) VICTOR Allen ECKER | | | 2. DATE AND HOUR OF DEATH
12/19/65 | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

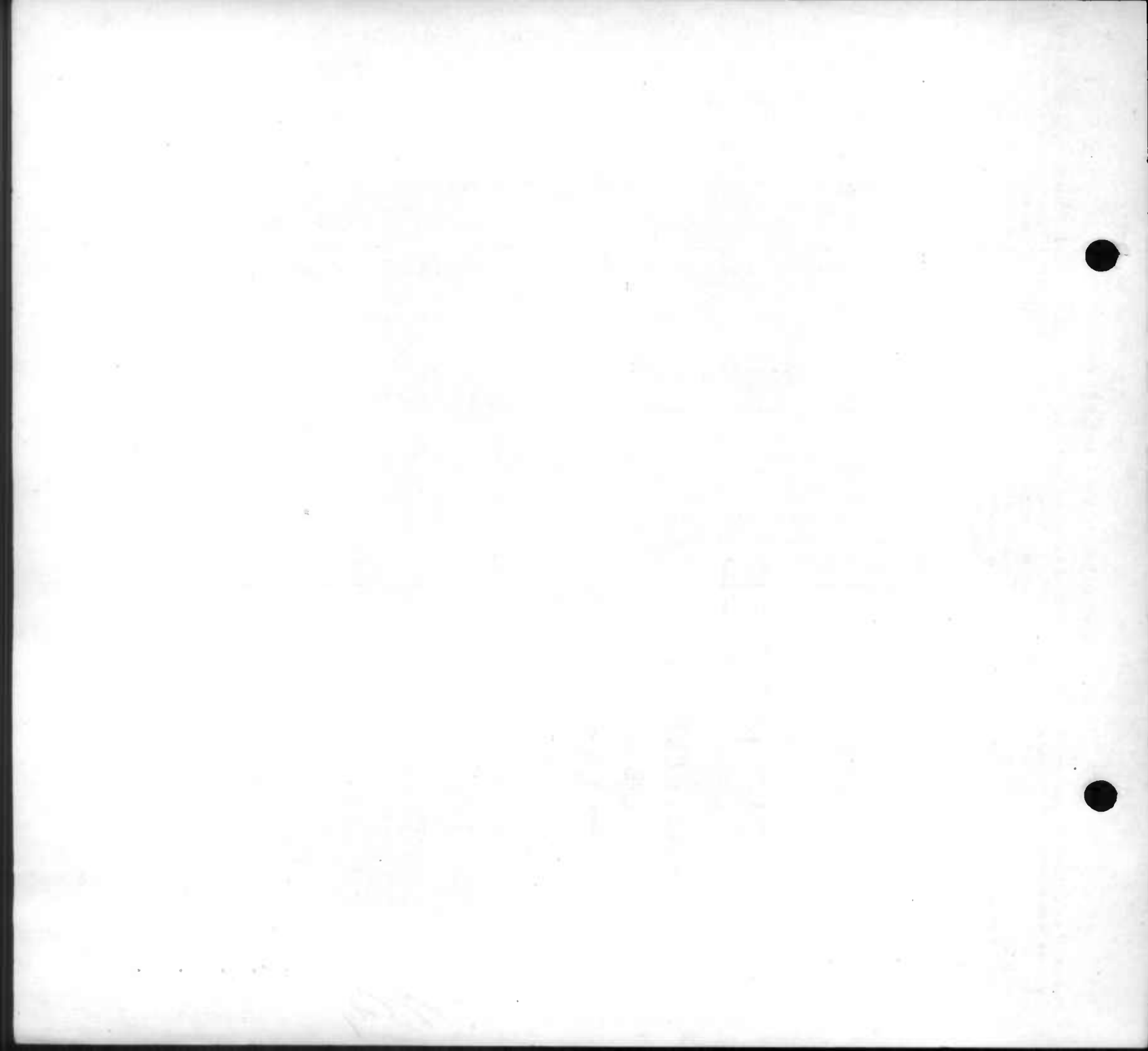
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
South Baltimore General Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY 23-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
113 W. Randall Street | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
5-1-82 | 9. AGE (In years last birthday)
83 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Assist Supt of Adm Spring Grove Hosp | | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
John W. Ecker | | | 14. MOTHER'S MAIDEN NAME
Mary L.F. Ecker | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-36-6771 | 17. INFORMANT
Mrs Helen E. Tumbler, 3415 Clarks Ln, Bal 15 | | |
| 18. 451X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)
Ruptured abdominal aneurysm | | CAUSE OF DEATH
(A) DUE TO
General arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH
4 days | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | years | |
| (C) | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
12-16-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
same | | 20A. AUTOPSY? (Yes or No)
no | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
- | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
- | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
- | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
- | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
- | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
- | |
| 22. I certify that (I) (this hospital) attended the deceased from June 11, 1964 to Dec. 19, 1965 , that (I) (we) last saw the deceased alive on Dec. 18, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
C.C. Chiu | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
12-20-65 |
| 23C. PHYSICIAN'S NAME (Type)
C.C. Chiu | | | 23D. ADDRESS
M.D. 1 E. Randall Street, Baltimore 30, Md | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12/20/65 | | 24C. NAME OF CEMETERY or CREMATORY
Loudon Park Cemetery | |
| 24D. LOCATION
Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 21 1965 | | 25B. NAME OF REGISTRAR
John W. Ecker | | 25C. FUNERAL DIRECTOR
McGuffey Funeral Home, 130 E. Fort Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

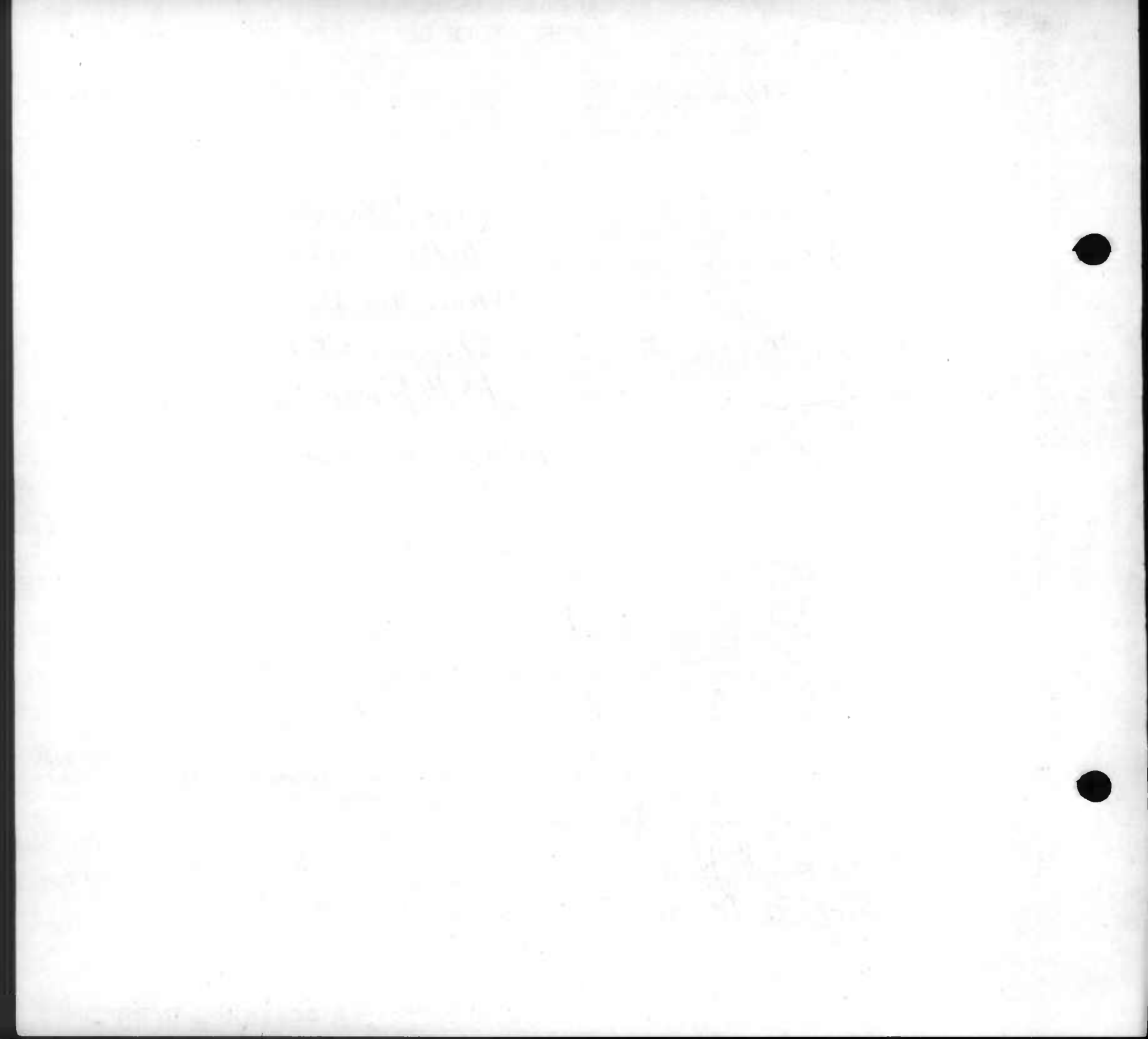
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 12996 | |
|--|-------------------------|--|-------------------------------------|--|---|
| BIRTH NO. 65 12996 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Barbara Anthony</i> | | 2. DATE AND HOUR OF DEATH
<i>12-19-65 2:00 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>Franklin Square Hospital</i> | | C. CITY OR TOWN. (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<i>1426 HAUBERT ST.</i> | | | |
| 5. SEX
<i>Female</i> | 6. RACE
<i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>Married</i> | 8. DATE OF BIRTH
<i>12-18-46</i> | 9. AGE (In years last birthday)
<i>19</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>none</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | | 13. FATHER'S NAME
<i>Daniel Gooddard</i> | | 14. MOTHER'S MAIDEN NAME
<i>Annie Sowers</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>unknown</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
<i>same</i> | |
| 18. <i>171X</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <i>Cancer of Cervix</i>
DUE TO
(B)
DUE TO
(C)
DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>December 15, 1965</i> to <i>December 19, 1965</i> , that (I) (we) last saw the deceased alive on <i>12-19-65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Ramon V. Luery</i> | | M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>12-19-65</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Ramon V. Luery</i> | | 23D. ADDRESS
<i>130 E. Fort Ave</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>12 23 1965</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Cedar Hill</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Brooklyn, A. A. Co. Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>DEC 21 1965</i> | | 25B. NAME OF REGISTRAR
<i>R. E. Jones</i> | |
| 25C. FUNERAL DIRECTOR
<i>R. E. Jones</i> | | ADDRESS
<i>130 E. Fort Ave</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|--------------|--|---|---|-------------------------------------|
| BIRTH NO. 65 12997 | | M.E. CASE NO. 65 12997 | | 65 12997 | |
| 1. NAME OF DECEASED
(Type or Print) HARTLEY, BABY BOY | | | 2. DATE AND HOUR OF DEATH
12/16/65 4:28 PM | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
UNION MEMORIAL HOSPITAL BALT. MD. | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALT. MD. 27-05 | | |
| D. STREET ADDRESS (If rural, give location)
6412 WALTER BLVD | | | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
12/16/65 | 9. AGE (In years last birthday)
15 mo | 10. CITIZEN OF WHAT COUNTRY?
USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country)
UNION MEM HOSP | | |
| 13. FATHER'S NAME
HARTLEY MILTON F | | | 14. MOTHER'S MAIDEN NAME
SHARON LEE | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT
H S Hoffman | | | ADDRESS
UNION MEM HOSP | | |
| 18. 762.51
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
PREMATURITY SEVERE | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | INTERVAL BETWEEN ONSET AND DEATH
22 | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
No | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
No | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)
No | |
| 21D. TIME OF INJURY (APPROX.)
No | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>
No | | 21F. HOW DID INJURY OCCUR?
No | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/16 4:16 PM 19 65 to 12/16/65 4:30 PM 19 65, that (I) (we) last saw the deceased alive on 12/16 4:16 PM 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Leonard S Hoffman | | | | 23B. DATE SIGNED
12/16/65 | |
| 23C. PHYSICIAN'S NAME (Type)
HOFFMAN, LEONARD S | | | | 23D. ADDRESS
UNION MEM HOSP | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
2 | | 24B. DATE
DEC 21 1965 | | 24C. NAME OF CEMETERY or CREMATOR
ANATOMY BOARD OF MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 21 1965 | | 25B. NAME OF REGISTRAR
R. A. R. [Signature] | | 25C. FUNERAL DIRECTOR
MORTUARY SERVICE - BCHD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|---|--|---|---|
| BIRTH NO.
65 12938 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 65 12938 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) Anna Mae Johnson | | | 2. DATE AND HOUR OF DEATH
December 17, 1965 12:10 p.m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Provident Hospital
1514 Division Street
Baltimore, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
2446 Etting Street | | |
| 5. SEX
female | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Separated | 8. DATE OF BIRTH
12/25/19 | 9. AGE (In years last birthday)
44 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S. | | | 13. FATHER'S NAME | | |
| 14. MOTHER'S MAIDEN NAME | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
331X I
C.V.A. | | | CAUSE OF DEATH
INTERVAL BETWEEN ONSET AND DEATH | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Severe an. disease | | | 20. DATE OF OPERATION
1965 | | |
| 21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner) | | | 22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 23. TIME OF INJURY (Month) (Day) (Year) (Hour) | | | 24. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 25. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 26. HOW DID INJURY OCCUR? | | |
| 27. I certify that (I) (this hospital) attended the deceased from 12-16 1965 to 12-17 1965, that (I) (we) lost saw the deceased alive on 12-17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | 28. DATE SIGNED
12-20-65 | | |
| 29. SIGNATURE
D. R. G. A. V. D. | | | 30. PHYSICIAN'S NAME (Type)
D. R. G. A. V. D. | | |
| 31. ADDRESS
1514 Division Street | | | 32. DATE
DEC 20 1965 | | |
| 33. NAME OF CEMETERY or CREMATORY
UNIVERSITY MEDICAL SCHOOL | | | 34. LOCATION
MORTUARY SERVICE - BCHD | | |
| 35. DATE REC'D BY HEALTH DEPT.
DEC 21 1965 | | | 36. NAME OF REGISTRAR
J. G. S. O. O. I. 1800 | | |

THE UNIVERSITY OF CHICAGO
LIBRARY
520 EAST 58TH STREET
CHICAGO, ILL. 60637

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 12999 | |
|---|-------------------------|--|------------------------------------|--|---|
| CERTIFICATE OF DEATH | | | | Registered No. 65 12999 | |
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) REED, Gilbert NMI | | | | 12/21/65 12/45 a M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Maryland 21218 | | A. STATE
Maryland
B. COUNTY
13-02 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location)
2108 Bolton Street | | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Divorced | 8. DATE OF BIRTH
10/9/18 | 9. AGE (In years last birthday)
47 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY
unknown | | 11. BIRTHPLACE (State or foreign country)
Lynchburg, VA | |
| 13. FATHER'S NAME
Gilbert Reed | | 14. MOTHER'S MAIDEN NAME
Iva Johnson | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 10/29/42-2/15/43 | | 16. SOCIAL SECURITY NO.
218-06-2573 | | 17. INFORMANT ADDRESS
VA Hospital Records Baltimore, Md 21218 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
Carcinoma Of Larynx
DUE TO
Pulmonary Tuberculosis Bilateral | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
3-6 Months | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (U) (this hospital) attended the deceased from November 19th 19 65 to December 21st 19 65 , that (U) (we) last saw the deceased alive on December 21st 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (U) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
 | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
William B. Joy | | 23D. ADDRESS
M.D. 3900 Loch Raven Blvd., Baltimore, Md. 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12/24/65 | | 24C. NAME OF CEMETERY OR CREMATORY
Baltimore National | |
| 24D. LOCATION
Balt. | | 24E. LOCATION
Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 23 1965 | | 25B. NAME OF REGISTRAR
E. E. Smith | | 25C. FUNERAL DIRECTOR
Garb Gilman | |
| | | | | ADDRESS
1827 W. North Ave | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 13000 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 13000 | |
|--|---------------------|--|--|---|----------------------------|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) PAULINE OSTROWSKI- OSTER | | | | 2. DATE AND HOUR OF DEATH
DEC. 17, 1965 10:30P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
44 UNION MEMORIAL HOSP. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY 27-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTO.
D. STREET ADDRESS (If rural, give location)
3907 WILKE AVE. 21206 | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
MAR. 22, 15 | 9. AGE (In years last birthday)
50 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SALESLADY | | 10B. KIND OF BUSINESS OR INDUSTRY
DEPT. STORE | | 11. BIRTHPLACE (State or foreign country)
MD. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
ANTHONY CEPHALIS | | | 14. MOTHER'S MAIDEN NAME
ANN | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
EDW. OSTROWSKI | | | |
| | | | | ADDRESS
3907 WILKE AVE. BALTO. MD. 21206 | | | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) Coronary artery occlusion
DUE TO
(B) Arterial Hypertension
DUE TO
(C) _____
INTERVAL BETWEEN ONSET AND DEATH
1 hour
11 years | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 11 1965 to Dec 17 1965 , that (I) (we) last saw the deceased alive on Dec 17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE E. J. Alessi | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
12/18/65 | |
| 23C. PHYSICIAN'S NAME (Type)
E. J. Alessi | | 23D. ADDRESS
M.D. 6217 Harford Rd | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
12-21-65 | | 24C. NAME of CEMETERY or CREMATORY
Holy Rosary Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
DEC 22 1965 | | 25B. NAME OF REGISTRAR
Robert E. [unclear] | | 25C. FUNERAL DIRECTOR
W. F. [unclear] | | | |
| | | | | ADDRESS
2007 Eastern Ave. Balto Md. 21231 | | | |

